The human encounter with death : An anthropological approach.

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THE HUMAN ENCOUNTER WITH DEATH: AN ANTHROPOLOGICAL APPROACH

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ABSTRACT

The thesis explores the quality of death-related experience, that is the semantic resonance of acts, events and utterances taking place in time and space framed predominantly by death. It draws on an anthropological/hermeneutic understanding that meaning arises out of the relationship between an act/event/utterance and its cultural and social setting. The source selected is Ricoeur's work on the relationship between text and context.

Accordingly, the historical background to the contemporary Western encounter with death is explored. An aspect of the scientific revolution of the sixteenth century is the emergence of a controlling rather than interpretive orientation towards the natural world. Medicine's role in controlling death has been important in the creation of the present boundary between life and death. The quality of contemporary death-related experience is understood within this context.

The three areas selected for study through participant observation are (1) Hospice death (2) ageing in residential care (3) bereavement. These contexts reveal the limits of a medical model of the relationship between life and death. The slow deterioration of old age is shown to present problematic ambiguities within a culture committed to maintaining a rigid life/death boundary. Similarly the death of a partner can raise difficulties for bereaved individuals unable to make a clear separation between a shared past and a solitary present. Hospice care and bereavement counselling are contemporary responses to a divisive and de-humanising life/death boundary. Through bereavement counselling the continuum of a past shared life, a current loss, and an independent future life can be reintegrated. Through Hospice care, dying can be openly acknowledged and

managed, so effecting the social, emotional and spiritual reintegration of dying individuals and their survivors.

Together these contexts reveal the ways in which an awareness of death may be culturally and socially deflected - or directed.

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PREFACE

The fieldwork, study and writing which this thesis represents has been a pivotal point in six years of apparently disparate endeavours or pursuits. These include forays into philosophy, linguistics and literary criticism; training in counselling skills; the avid consumption of novels, films and television programmes about death and dying; participation in the bereavements of friends and neighbours; the writing of poems; and the teaching and organisational work involved in establishing a bereavement support service in my own neighbourhood. The pursuit of an academic study of death has produced a way of life in which the intellectual, emotional and practical issues of human mortality have predominated. On more than one occasion a phone call from a widow seeking support through a particularly painful day has interrupted highly theoretical reading addressed nonetheless to the cultural and social framing of process.

Circularities of this kind have pervaded the period through which I have been working. In tandem with academic study my personal understanding and appreciation of the life that I have had and the life that remains to me have been developing steadily throughout the past six years.

Enormous support has been given to me, from a wide variety of sources. In the summer of 1977, at a distressingly confused point in my personal life, death was the topic of an initial, extended conversation which I sought with David Brooks in the Anthropology Department at Durham University. His responses opened up an astonishing vista which I am still exploring. The enthusiasm and the insightfulness which he offered on that occasion have been available to me continuously throughout his six years' supervision of my later research. It has been a turning point and I will always be indebted to him.

Judith Okely, Allison James, Marie Johnson, Malcolm Young, Bob Simpson, Peter Phillimore, Joan Knowles, John Malley and Ian Edgar have provided me with an intellectual and social context which is special and enduring. The gradual geographical dispersal of this research group is a great loss - but their continued commitment and support is invaluable. To Judith Okely I am particularly grateful for an irresistible invitation into the fields of personal anthropology and research within my own society. Peter Phillimore has given me generous help in preparing Chapter Four of the thesis.

David Harris at the Social Services Department in Durham City, Bel Wilson at the Newcastle branch of the Cruse Organisation for Bereaved People, and Inge Samwell at Strathcarron Hospice, Stirling, readily gave me critical points of entry into fieldwork. During unnerving and lonely field experiences Bel Wilson and Inge Samwell watched closely and helped me to discover the necessary personal resources. Similarly the tireless patience and good humour of the care staff who guided me into and through the disorienting environment of a residential home for elderly people has been invaluable.

Central to the project is the trust offered me by individuals who were suffering both physical and emotional pain. Very few of them remain alive today. Their capacity to be both open and vulnerable is an important legacy for younger adults often culturally constrained by an excluding sense of privacy, a narrow commitment to autonomy and a concept of growth which disallows decline.

Finally my thanks are owed to the friends and family who accompanied me through an otherwise lonely period of study. In particular Carole Seheult and Dorothy Neave have actively shared in my enthusiasm, offered me companionship, and left me alone to get on with it. Bob, Joanna and Gareth Hockey, my immediate

family, provide me with the safe place from which I set out and to which I return. I count myself very fortunate in this respect. In 1973, on a hillside above Kettlewell in Yorkshire, my husband Bob gave me the then novel idea of pursuing a degree course in Social Anthropology. I will always be grateful for his suggestion.

This thesis is dedicated to the memories of Meredith Watling, Lorna Manning, Bill Bennett, Eileen Carr and Bill Davison. Their lives provided the inspiration and the deaths the challenge which have made its completion possible.

Jennifer Lorna Hockey
Sheffield, September 1986.

NOTES ON THE FORM OF PRESENTATION

(1) With the exception of 'Strathcarron Hospice', the names of all individuals and institutions have been changed in order to maintain confidentiality.

(2) Anthropological research within our own society is only now developing. The 'exotica' of native terms to be found in traditional monographs effectively reminds the reader that language is a primary focus, that its meaning may not be apparent but requires careful exposition. When reader and informant share the same body of 'terms', or language, its deeper semantic resonance may be passed over. In order to stress the significance which 'everyday' language takes on through the proximity of death I have used a bold typeface to present the direct speech or 'terms' used by informants.

(3) Superscript numbers within the text refer to notes at the end of each chapter.

PART ONE

AN ANTHROPOLOGICAL APPROACH TO THE MANAGEMENT OF DEATH IN WESTERN SOCIETY

CHAPTER ONE

FROM AN ANTHROPOLOGICAL PERSPECTIVE: WAYS OF THINKING ABOUT THE MANAGEMENT OF DEATH

Behind this thesis lies an accumulation of anthropological work addressed to the study of death ritual in societies outside or on the fringes of our own. Working at the end of the nineteenth century, Frazer and Tylor can be seen as its initiators. Within their work the uncertainties of the human encounter with death were seen as the primary source of religious activity. Viewed as a faltering attempt at 'science', religion is described by Frazer and Tylor as an attempt to provide intellectual solutions for the dilemmas of human existence - most notably the fate of the dying individual. Alongside this thesis stands a body of more recently generated work concerned with the management of death in Western society. Since the 1950's, psychiatrists, historians and sociologists have been addressing themselves to this topic.[1] The intersection of these two bodies of work provides the starting point for a discussion of the anthropological perspective through which I have approached the management of death in contemporary Britain. As a focus for work within a variety of disciplines, the topic 'death' refers to an extensive and largely unbounded area of thought and experience. In this initial discussion two approaches to the topic are particularly relevant.

First, there is the perspective offered by present day anthropological theory which derives from extensive study of the cultural forms of non-Western societies. Like gender or handedness, ageing, dying and death are universal areas of human life which, when examined cross-culturally, reveal the variety of cultural forms through which the members of different societies conceive of and experience themselves and the world they inhabit. The body of anthropological work addressed to death and death ritual demonstrates the universality of certain themes which emerge in association with death - for example, the transience of

individuals and the re-allocation of social roles; concepts of time; and questions about the relationship between human beings and their surrounding cosmos. It also reveals a coherent relationship between death ritual and the pervasive cultural forms of a particular society.

Second, there is the explicitly 'critical' approach adopted by members of a broad range of disciplines. Its focus is described by Martins as 'the social invisibility of death' in the Western world (1983:xi-xv). By this he is referring to a cultural ideal of a discrete and emotionally low-key death; to cremation as practised in Great Britain; and to a diminishing of outward social forms for the expression of grief. As Martins points out, much of the work which sets out to offer a critique of these approaches also goes on to make comparisons between contemporary Western practices and death ritual at other times and in other places. Historical and anthropological material is seen to yield the possibility of a more meaningful, therapeutic and dignified mode of disposing of the dead. What Martins describes as 'death utopias' are discovered in non-Western societies, often in social contexts where a broader examination would reveal underprivilege and punitive social controls.

Anthopological monographs have freqently been plundered in the search for such images, spatially and temporally distant from the here-and-now of the contemporary Western reader, closer to a lost world of nature. Detailed and more extensive reading of this material brings up monographs such as Turnbull's 'The Mountain People' (1973), an account which reveals 'nature' to be disturbingly red in tooth and claw.

Cannadine notes that historians have made similar utopian or nostalgic interpretations of the death ritual of previous periods in Western history (1981). Victorian death ritual has been a particular focus in the work of Aries (1978) and Stannard (1977:188-94) where, Cannadine notes:

> ...if grieving in the nineteenth century was successful, death was almost pleasurable. (1981:188)

Such attempts to evaluate ritual forms within other societies are valid endeavours. There is variation in the extent to which a society's cultural forms can be said to offer an expansive set of metaphors through which death, or indeed any other aspect of life, may be encountered. Nonetheless Martins is appropriately sceptical about the breadth of perspective of some writers. It is here that an anthropological approach can offer the possibility of critical evaluation rooted in a broader and a deeper appreciation of the cultural and social context of death.

Thus the focus of anthropological work stemming from a structuralist or hermeneutic perspective is the set of generative principles through which all aspects of the cultural and social life of society are organised and made sense of. Death ritual has repeatedly been shown to encapsulate the cultural values or themes which are central to a particular society, giving them their most powerful expression when an individual member dies. As such, a funeral is an often critical event for the anthropologist exploring one specific social group. If the 'success' of death ritual can be discussed at all usefully, it is with respect to its power to express and to recreate those central values or issues in a convincingly authentic fashion. Exotic or bygone death ritual may appear to contain certain elements, such as an elaboration of detail or an abundance of emotional expression, which correspond closely to those dimensions felt to be lacking in Western arrangements. This perception however is revealing largely with respect to Western death ritual itself. It can be related to a more generally felt need for both a more 'natural' and a more secure and predictable way of life in the West. It is often anthropological and historical material which is made ready use of in the imaging of such a lifestyle.

For example in the diet, dress and emotional and bodily style of the last twenty-five years a 'naturalness' attributed to 'primitive peoples' has been evoked among the members of prominent social categories in the West. More recently, domestic furnishing, literary preferences and political rhetoric have reflected the imperialist power and domestic formality enjoyed among certain social classes during the Victorian period in Great Britain.

Thus what is often uncomfortably reflected in the contemporary social invisibility of death in the West is social fragmentation and an increasing disregard for institutionalised religion. It is out of the experience of current ritual that the recent pre-occupation with elaborate, emotionally expressive 'primitive' or Victorian death ritual has arisen. In itself this pre-occupation is a reflection of current Western images of a more fulfilled, dignified and stable way of life.

Thus an anthropological perspective can reveal negative as well as positive correspondences within one particular society. Cross cultural studies also demonstrate the enormous variety of cultural metaphors through which universal issues associated with death may be conceived of and managed. It offers a reminder that the criteria such as 'dignified', 'therapeutic', 'tasteful' are particular to our own society. They are inadequate reference points in making an evaluation of death ritual in other societies. It is through their commitment to the particular, that cross cultural studies offer the more fruitful possibility of advancing our understanding of the general, universal themes or issues which arise at the time of death. As noted these include concepts of time, the self, and the meaning of life - themes which indeed merit Geertz's term, 'grand realities' (1975:21). Discussing this question Geertz argues that a discipline grounded in fieldwork allows anthropologists to explore such themes in particular, small-scale social contexts -

both intensively and over extended periods of time. In this way, he suggests:

> These all-too-human constancies, 'those big words that make us all afraid', take a homely form in such homely contexts. But that is exactly the advantage. There are enough profundities in the world already. (1975:21)

Lying behind the thesis in hand, it is the insights produced through repeated use of this strategy which facilitate the reflexivity necessary for an exploration of such 'grand realities'- as they are currently being managed through the cultural metaphors particular to the West.

The following three sections of this chapter set out in more detail the approaches which an anthropological perspective comprises.

(1) General points will be established about cultural systems with respect to the encountering and the managing of the conceptual, emotional and bodily disorder introduced into life by death.

(2) Anthropological ideas about the cultural and social elaboration of the biological event of death will be explored. Stress will be laid on the variety of ways in which the relationship or boundary between life and death is culturally conceived and elaborated.

(3) There will be an introduction to some of the ways in which conceptions of, and moods associated with, death may be brought into being through the ritual process.

1 CULTURAL SYSTEMS AND THE ENCOUNTER WITH DEATH

Two aspects of contemporary Western practises associated with death which repeatedly become a focus in academic and more popular critiques are the felt inauthenticity of religious ritual and the inadequacy of current medical models. For example, Gorer writes:

> ...the majority of British people are today without adequate guidance as to how to treat death and bereavement and without social help in living through and coming to terms with the grief and mourning which are the inevitable responses in human beings to the death of someone whom they have loved. (1965:110)

Similarly Illich states that:

> Today, the man best protected against setting the stage for his own dying is the sick person in critical condition. Society, acting through the medical system, decides when and after what indignities and mutilations he shall die. The medicalization of society has brought the epoch of natural death to an end. (1975:149)

An extended discussion of changes in the management of death in the West during the transition from an age of faith to a more secular, medicalized society will be presented in Chapter Three. For the present I am limiting discussion to the idea that both religion and medicine can be seen as cultural systems through which death may be managed.

I have begun by noting the distresses and dissatisfactions expressed throughout the critical literature. As negative examples they provide a starting point in discussing how cultural systems come to provide plausible and effective frameworks through which death may be encountered. As ethnographic material from non-Western societies shows, these frameworks have traditionally been of a religious nature. Outside modern Western

society healing, care of the dying, disposal and mourning have all been managed according to religious frameworks. Setting aside our own understanding of religion and medicine as distinct and separate areas of cultural and social life, we can turn to material stemming from societies where religious thought and experience pervades and gives meaning to every aspect of life. In such a setting there is no space apart, no separate reference point, for a solid body of critical thinking of the kind which underlies the recent literature on death in the West. This is not to say that it is the absence of alternative modes of thought alone which accounts for the power and effectiveness of religious ritual in other parts of the world.

Sharma has shown that inconsistences or 'tensions' do exist within religions such as Buddhism or Hinduism (1973:343-364). The difference, in these cases, is that despite a tension between what is said or laid down regarding a religion, and how religion is actually felt and expressed, what Sharma is essentially discussing is a variety of interpretations of single, authoritative bodies of religious doctrine. Nonetheless it is the pervasiveness and consistency of a particular (religious) mode of thought which characterises much non-Western death ritual and its relationship with all aspects of a particular culture.

In the West 'religion' has come to refer to beliefs and practices which still retain the power to inspire emotions such as respect or even awe. However as an interpretation of the nature and meaning of human experience current religious practice often fails to reinsert the individual effectively within their own experience. It is medical and psychological, rather than religious models of living and dying which increasingly are resorted to as a sufficient account of human experience. A willingness to submit to mutilating or humiliating medical treatments and anger over the 'inadequacy' of human medical practitioners are dispositions indicating that these are models which evoke enormous expectations - ones which may be held with

the unquestioning trust of a religious faith.

Illich makes a clear distinction between current and more 'traditional' approaches to suffering and death:

> Culture confronts pain, deviance and death by interpreting them; medical civilization turns them into problems which can be solved by their removal. Cultures are systems of meanings, cosmopolitan civilization a system of techniques. (1975:93)

Today, in the West, it is often within the latter cultural milieu that death is encountered, the dead are disposed of and the bereaved seek some kind of survival. As a cultural system, it can be described as a structure of control which operates within specific sets of boundaries. That is to say suffering is made manageable through its removal or reduction. Suffering which escapes such a model is nonetheless similarly managed in that it is distanced and avoided. Those individuals unable, finally, to escape suffering often find themselves isolated within their own physical and emotional conditions, deprived of any vehicle through which their experience may be made meaningful and therefore sufferable. Geertz describes the insufficiency of commonsensical systems of this kind as follows:

> ...the events through which we live are forever outrunning the power of our ordinary, everyday moral, emotional, and intellectual concepts to construe them, leaving us, as a Javanese image has it, like a water buffalo listening to an orchestra. (1968b:101)

In summary, ambiguous responses are evoked by both medical and religious models of ageing, dying and death. As a cultural system medical or scientific models are often experienced as ultimately limited in that they make only a narrow range of human experience manageable - and in that distancing and control rather than encountering and interpreting are their primary techniques. By turn 'religious' models are often experienced as 'inauthentic' -

that is to say, as an interpretive framework, their symbols bear only obliquely upon the experience of many members of Western society. Largely absent is any persuasive fusion of the cosmic and the personal dimensions of experience, through which each becomes re-animated by the other. Thus for those who stand outside or on the fringes of the established church or other cohesive religious groups, the legal requirement of an institutionalized ceremony of disposal often results in the disturbing experience of ritual which is found to be both evocative yet unconvincing at one and the same time. Moore and Myerhoff point out that:

> ...beneath all rituals is an ultimate danger...the possibility that we will encounter ourselves making up our conceptions of the world, society, our very selves. We may slip in that fatal perspective of recognizing culture as our construct, arbitrary, conventional, invented by mortals. (1977:18)

At the time of a bereavement, the grief of those whose religious faith is absent or wavering can be compounded by required attendance at a ritual which in principle conceals but in practise reveals to those individuals the constructed, arbitrary nature of the 'given' beliefs and values of the established Church - through which the self and the surrounding world has hitherto been conceived and experienced.

Writing in 1907, Hertz observed that:

> ...when a man dies, society loses in him much more than a unit; it is stricken in the very principle of its life, in the faith it has in itself. (orig.1907; 1960:78)

The over-riding aim of his essay is to demonstrate that death is a social rather than merely biological event. His terms of reference are the 'needs' of society to 'feel itself immortal'. Though he interprets death ritual in terms of the loss of the

individual and therefore of society's investment in the individual, his argument is congruent with the notion that there is a requirement, particularly at times such as a death, that cultural frameworks be experienced as given, unquestionable and enduring. Current dissatisfaction with death and mourning ritual, coupled with nostalgic sideways or backwards glances towards exotic or bygone forms, reflects the persistence of this requirement. Furthermore, given that religious belief in Great Britain today is in many senses partial, the couching of all death ritual at least minimally within a religious aesthetic readily evokes the major issues to which religious experience addresses itself but now, no longer, provides a universal resolution. Indeed, while ritual associated with birth and marriage is more readily dispensed with or enjoyed merely as tradition or colourful ceremony, the quality and character of ritual associated with death continues to be a focus for powerful emotion. When priest and liturgy, deceased and bereaved are meeting for the first time, the resulting lack of personal significance experienced by survivors may cause their grief to deepen into a more pervasive sense of loss as 'meaning' itself becomes questionable.

In summary, the central issue which arises when critiques of Western death ritual are placed in the context of cross-cultural studies is that the occasion of a death implicitly calls into question both the permanence and the authenticity of the cultural frameworks through which meaning is read out of all aspects of life within a particular society. As Moore and Myerhoff point out, rituals are dramatic, participatory events in which potential areas of disorder, paradox and fragmentation are represented (and experienced) as whole, ordered and meaningful (1977:17). Thus the deliberate, ritual construction of the experience of order, meaning or wholeness inevitably involves the transformation of an arbitrary, made-up sequence of events into an unquestionably authentic demonstration of that order. Criticism of present-day death ritual not only calls attention to

the lack of social forms currently experienced as meaning-giving, it also, implicitly, decries the experience of participating in/attending a ritual which results in the arbitrary nature of an entire system of values and assumptions being made disturbingly apparent.

With contemporary criticism of Western practises related to death as my starting point I am therefore arguing that in many of the more traditional or small-scale societies which have been studied by anthropologists, death is managed through practises which are:

(1) markedly consistent with the broad and pervasive cultural frameworks of that society.

(2) particularly persuasive expressions of the continuing and permanent nature of those frameworks

(3) structured in such a way that a maximally authentic and convincing experience is produced within the believer.

To the extent that contemporary Western practices associated with death fail to move the individual and instead constitute an unwelcome expression of de-humanising aspects of our own society, they have become a recurrent focus for social criticism. In the next section I will develop this theme using ethnographic examples to show how the issue of 'meaning' is variously managed.

2 'LIFE' AND 'DEATH': THEIR FRAMING AS CULTURAL CATEGORIES

Hertz's work demonstrates the social dimension of the biological event of death and the emotions which it arouses (Hertz, orig. 1907; 1960). Moreover his interpretation of fieldmaterial from the Dayak peoples of Borneo develops the idea that death can be thought of and experienced as process as well as event; that

death rituals can be seen as rites of transition from one state or status to the next. It is out of the shape of that time and space between life and death that each can assume its culturally specific nature.

Thus by making an explicit separation between these two categories, the one defined in opposition to the other, the idea and the experience of cultural and social continuity or transcendence can take on substance. Virtually every death carries with it the power to evoke a sense of disruption and disorder. A great deal of ethnographic material is devoted to the very profound and far-reaching implications of the death of a leader.[2] For example where the body of the king is expressive of the continuity of the political order, its deterioration, death and decay may precipitate a far-reaching state of political imbalance. However even the death of an individual who is socially relatively insignificant implicitly carries the power to threaten assumptions about the nature of things.

The following material shows that a sense of cultural and social continuity can be fostered through an acknowledgement of the physical reality of decomposition and death. Each example describes a social context which is located geographically within the West but which represents a quite distinctive and different cultural system. The opposition, and the relationship, between the cultural categories 'life' and 'death' is strongly elaborated in each case. The focus of subsequent chapters is similarly the opposition or separation of 'life' and 'death' which prevails more generally within Western society. The ethnographic material selected in this chapter, by virtue of its 'foreignness', raises questions about the nature of the life/death boundary, and the varying metaphoric forms or images through which it is managed.

Du Boulay's paper addressed to cyclic symbolism in marriage and death ritual in rural Greece (1982) is a particularly striking example and I will discuss it at length. She describes the way

in which dying is conceptualised and the ritual forms brought into play by a death. Briefly, it is through the image of the slashing of the dying person's throat by Charos, the angel of death, that the moment of death is represented. Then, with the last breath, the soul leaves the body. Blood, violently released by Charos, pollutes the body, house and household and is purged only through washing, changing of clothes and, formerly, whitewashing of walls. Once cleansed the body is transformed into a state of precarious holiness which is maintained only through the care of mourners. On the body's navel a flat spiral candle made up of coiled threads, each one the length of the body, burns from the centre in an anti-clockwise direction during the three nights of the wake. Stringent care is taken to avoid the passage of anything (cups, cushions, a child or an animal) across the body. All are passed, hand to hand, around the body. Failure to observe this precaution brings about the demonic possession of the soul. The body is then re-animated in the form of a vampire which returns, seeking the blood of its own family, and is defeated only through the irrevocable destruction of the deceased's soul.

Du Boulay sets this material within the context of village life past and present. In keeping with the general points already established in this chapter, she shows how the centrality of blood and of the auspicious, right-handed spiral resonate throughout many other areas of life. In death ritual they receive their most emphatic expression. Failure to maintain a continuity of thought and imagery at the moment of death precipitates the embodiment of terror, the vampire lying gleaming-eyed in its grave, emerging to penetrate the noses of its kin and drink their blood. Having demonstrated an overall consistency of cultural and social forms within the life of the village, Du Boulay then shows in detail how cyclic imagery, the ordering principle of marriage patterns and of dance, is used in the structuring of the relationship between the cultural categories 'life' and 'death'.

Thus the separation of the body and blood of physical life from the soul of spiritual existence is precipitated by Charos' bloodletting. Ritual acts of purging, candle-lighting and encircling rather than crossing the body are the ways in which such a separation must be actively created and maintained. Only burial assures it. Only then can the equivalence of blood with life be opposed to the bloodlessness of death. Full-blooded village life involves 'vivid and vital face-to-face relationships'. In the shadowy 'other world' the bloodless dead drift in endless motion, right hands stretched out behind them in unseeing encounters with their half-forgotten fellows. The possibility of such an opposition rests upon the careful separation of the conceptual categories 'life' and 'death'. Failure to maintain the separation brings about the blurring of the two categories in the terrifying, ambiguous form of the vampire, a devil-possessed soul which re-animates its own undecaying corpse. The principle of an auspicious spiral flow of blood, expressed in the movement of women out of their own homes to marriage among 'strange' kindred, is suddenly, dangerously, reversed. When women marry back into the kin group from which their male collateral kin have already taken a wife, this 'turning back' or 'returning of blood' precipitates misfortune; when passage across a body breaks the encircling ritual movements of mourners the living dead vampire returns to prey on the blood of its kindred.

Du Boulay sums up her discussion by pointing out that while Greek rural death ritual is firmly oriented towards the maintenance of a separation between the cultural categories 'life' and 'death', it is through the careful structuring of that separation that the possibility of transcendence is created. Charos' blood-letting separates body and blood from soul but in so doing sets the progression of the soul in motion. The cyclic imagery of marriage patterns and of the dance is recreated in the spiral candle and in the encircling of the body which ensure the safe

passage of the soul to the 'other world' where the dead drift in an endless sequence of right-handed encounters. As Du Boulay states:

> ...a continuity of understanding...informs the processes both of life and death. (1982:236)

She concludes:

> ...the spiral dance of life, while it divides irrevocably blood from non-blood and the living from the dead, at the same time permeates the opposed worlds of life and death, and transcends, though it does not reconcile, their opposition. (1982:236)

The separations and transcendence which Du Boulay describes are essentially conceptual processes. They are about the creation of order in the face of possibly the most imperiously enigmatic event of all. In this respect they can be set alongside the 'Order for the Burial of the Dead',[3] through which the Anglican Church structures the ritual disposal of the dead within our own society. Its liturgy postulates that 'life' is a fleeting passage, 'full of misery'; that the shedding of our 'vile' bodies prefaces the eternal life of the believer made possible through the resurrection of God's own son, Jesus Christ. The nature of the relationship between God and humankind, 'life' and 'death', is unambiguously revealed (by the priest) at the end of the burial service:

> Almighty God, with whom do live the spirits of them that depart hence in the Lord, and with whom the souls of the faithful, after they are delivered from the burden of the flesh, are in joy and felicity...

However what Du Boulay's material also demonstrates is the way in which emotion is engaged and focussed through performance of rural Greek death ritual. The threat of the vampire is far more than a nightmare folk-tale in that the exorcising of 'a great heavy woolly apparition' is remembered in disturbing detail by

all the older villagers. At issue here is the creation ofmeaning. Like the Anglican 'Order for the Burial of the Dead', Du Boulay's ethnography describes the acts and gestures through which 'order' or meaning may be demonstrated. It is however only though performance that such formuli take on meaning-in-the-world. As Du Boulay shows, death ritual in rural Greece is resonant within its immediate cultural and social context. It takes on referential meaning. What we may also infer is that cultural and social coherence of this kind will also allow for the generation of indexical meaning. That is to say the single and quite specific instance of one particular death may be encountered through a fixed ritual process which addresses the universal life cycle event, death.

As discussion in the previous section suggested, it is the dualistic generation of meaning, on both a cosmic and a personal level, which is often felt to be lacking with respect to death ritual within our own society. While the set of postulates which constitute the Anglican 'Order for the Burial of the Dead' has an internal coherence or sense meaning, it may resonate only in a negative fashion within the world view of the participant. For example they may come to feel that not only the life but also the meaning of the life of the deceased person has been lost.

These points are developed in Ricoeur's work on hermeneutics. He shows that it is possible to expand upon a purely cognitive explanation and offer an interpretation of how a particular quality of experience comes into being. Ricoeur describes structuralist analysis as explanation rather than interpretation in that it allows for an initial penetration of the surface of material such as text, myth, ritual or social interraction (1981:152-164). And indeed Du Boulay's work clearly is informed by structuralist principles of binary opposition and paradigmatic association. As such it carries an emphasis on the cognitive dimension of ritual associated with death. However, without further exploration, structural analysis alone represents little

more than 'a sterile game'. Associations and oppositions spring pleasingly to the surface and, as the pattern emerges, so the unwieldiness of field material diminishes. What remains to be elucidated however is what the oppositions and connections are about. Without this dimension we are left with unsatisfying explanations which reduce death ritual merely to a conceptual tidying-up process. Clearly there is a lot more to the 're-ordering' precipitated by death than the setting or transgressing of boundaries. As Ricoeur points out, Levi-Strauss describes mythical thought as centred on paradoxes and oppositions which are intrinsic to human life, for example conception, evil, incest and death (1968:210-11). Interpretations of myths not only reveal their structure but also show how a certain paradox and its inherent oppositions has been evoked and how a mediation is effected.

In summary, Ricoeur describes the structure of a myth, or indeed any material, as its internal or sense meaning, a logical system of entirely self-referential or semiotic significance. A semantic/hermeneutic interpretation shows the referential meaning which material takes on through its place within the world. Internal structure is transcended in the orientation of text/ ritual/speech towards the world outside itself.

Death is, in itself, clearly a conceptual enigma. It is also an occasion when the enigmas, paradoxes and conflicts of life and of a lifetime become pressingly immediate. As Charmaz points out:

> ...in essence the drama so frequently visible in the situations of the dying, suicidal and bereaved resembles a spotlighted and intensified version of what happens in everyday existence. (1980:6)

In Du Boulay's paper, she identifies the abstract term 'katameria', which is understood to refer to marriage rules and which has the approximate meaning 'a process of putting things according to their category'. 'Katameria' can therefore be seen

as a structuring principle, the explaining of which is the first stage of interpretation. In social contexts such as marriages and deaths 'katameria' acquires referential meanings concerned with fundamental issues such as the manipulation of good and ill fortune; individual survival after death; and the nature or essence of social relationships between individuals and groups. Sharing the common structuring principle of katameria, death ritual can be seen to evoke many of the key themes or issues within the culture of the village. Fused in the 'exotic' ritual elements brought together after a death, these issues are given emphatic, simultaneous and coherent expression. In Du Boulay's work the cognitive dimension of death ritual predominates. It nonetheless moves beyond a structuralist analysis, giving indications as to the context and texture of life and death, as they are shaped and framed in opposition and in sequence to one another.

Geertz stresses cognition as 'the characteristic function' and 'highest asset' of human beings (1968a:15). Making sense is critical even if only as an as yet unfulfilled possibility. His definition of religion includes the notion that it is a system of symbols through which 'conceptions of a general order of existence' may be formulated. In this respect he echoes Levi-Strauss (1966) emphasis on the capacity of the human mind, both 'civilized' and 'primitive', for abstract, intellectual theorising. What Geertz goes on to include in his definition of religion, however, is its role in giving shape to emotional experience. Through social forms such as icons, images or symbols an intense, inchoate, private emotion such as grief, is given an external, culturally meaningful form.

It is this emotional dimension of death ritual which is often unacknowledged or underestimated in anthropological accounts. This is the case particularly in monographs where death ritual is essentially being made use of as additional ethnographic evidence of a particular cultural and social system.[4] Nonetheless the

early essay by Hertz (orig.1907; 1960), though lacking in qualitative description of emotional experience, does take the social character of emotion as a primary theme. Like his teacher Durkheim's work on suicide (1897), Hertz's intellectually innovative essay focusses on an area of life hitherto thought to be a matter of entirely individual and private emotion.

Okely's discussion of gypsy death ritual (1983:215-230) is a counter-example of material which, although used as one part of a larger monograph, focusses clearly on the nature and on the expression of emotion at a death. As in all the examples to be presented in this section, Okely's material demonstrates the creation of a separation between the cultural categories 'life' and 'death'. As in other cases the conceptual ordering of this biological event has a broader field of referential meaning. In this case it is 'about' the nature of gypsy identity and gypsy/non-gypsy relations.

At the time of death, identity is a critical area of social life, one likely to be given maximal ritual expression. Indeed the inverse of this assertion is manifestly true, demonstrated in current events throughout the world where ethnic identity is the cause par excellence for which individuals are prepared to give their lives.[5]

For a social group such as gypsies, living on the margins of other more dominant groups and dependent upon them as an economic resource, the maintenance of ethnic identity is culturally elaborated as a key structuring principle within cultural and social life. Gypsies are a nomadic as well as marginal group and for them the body is an important focus for symbolic expression. Through bodily conceptions and bodily techniques the boundary which separates the social categories 'gypsy' and '<u>gorgio</u>' (non-gypsy) is given cultural and social form. Thus the outer body, polluted through necessary contact with <u>gorgio</u> society, and the inner body, expressive of pure gypsy identity, are maintained

in strict opposition to one another through a separation which permeates many areas of life. These include eating, washing, and animal classification.

At death, as at birth, the inner body can no longer be kept separate from and contained within the outer body. The dead body in its entirety and the spirit (mulo) thus become dangerously polluting, the objects of intense fear. Once the gypsy/gorgio separation can no longer be expressed through bodily boundaries, emphasis shifts to the boundary between the deceased and their cognates, between the dead and the living. As Okely says:

> The boundary between life and death is used to make symbolic statements about another ethnic boundary. (1983:230)

Almost every aspect of death ritual, from the place of death to the care of the grave, can be seen as expressive and affirming of the boundary between the survivors and the dangerous mulo. Intense fear of the dead is the emotion which prevails at this time and which has been noted by gypsiologists. What Okely's work shows is the structured significance of this emotion. Only through an elucidation of all aspects of gypsy culture and, particularly, of the centrality of the gypsy/gorgio boundary, can the intense fear asociated with the boundary between life and death be appreciated and understood as a socially meaningful response to death.

Crying is one example of emotional expression often thought of as a universal, individual response. Okely describes how gypsy dead are buried, at a safe distance, in gorgio churchyards. To the gorgio parson who conducted one such gypsy funeral, the uninhibited, even hysterical, wailing and sobbing of the congregation appeared 'very sad'. To authors of critiques of contemporary Western death ritual, active emotional discharge of this kind is often perceived as a desirable and therapeutic release of individual feelings. Using an anthropological

perspective, Okely shows such displays of emotion to be culturally and socially generated, part of a necessary process of appeasing and distancing an imminently polluting spirit.

The relationship between the cultural categories 'life' and 'death' among gypsies can therefore be described as tense. There is no gypsy afterlife, no transcendent relationship between these two categories. The biological process of dying involves a fusion of the inner and outer body which is entirely inconsistent with gypsy identity. In that the dead are made immobile in the gorgio space of the churchyard they can be said to have been dispatched for all time from a nomadic gypsy society and assimilated into the sedentary world of the gorgio. Cultural continuity is achieved not by an extension of the society of the living into the world of the dead but rather through the social death of those whose bodily condition cannot be seen as anything other than an inversion of gypsy ethnic identity. Continuity lies in the future, in the biological and cultural regeneration of the group through its children.

Parallels to gypsy death ritual can be found in Faris's work on Cat Harbour, a small Newfoundland fishing community (1973:45-59). Faris questions the presentation of accounts of cognitive systems of classification which are entirely detached from the past or present circumstances within which they were generated. His starting point is the system through which collective social events are classified in Cat Harbour.

Certain gatherings are recognised indigenously as 'occasions'. These include weddings, scoffs, funerals, birthdays, times and mummers. In seeking to establish the principles through which 'occasions' come to be perceived in opposition to other social events, church services, banquets, union meetings (which Faris terms 'non-occasions'), he explores Cat Harbour's history as a precarious settlement, illegally founded on the very periphery of the Newfoundland mainland. In the world view of its inhabitants

those who stand outside the local community are traditionally strangers of the most threatening kind. Local identity has been established in opposition to a harsh outside world of both mainland and sea-borne enemies.

Just as the maintenance of ethnic purity has been elaborated as a central structuring principle among gypsies, so an insider/outsider opposition permeates the cultural and social frameworks through which life in Cat Harbour is conceived and experienced. Outsiderhood provides the metaphoric concept through which all socially unacceptable behaviour is made sense of and controlled. Blackness is the image/colour through which outsiderhood is evoked. Open, volatile emotionality, whether precipitated by alcohol or by grief, whether displayed in sexually licentious behaviour or close peer-group friendships, is an example of behaviour perceived to be dangerously unpredictable and unguarded. Theft is a similarly deviant behaviour.

Having established the present role of a historical opposition between insiderhood and outsiderhood, Faris shows the common elements shared by social events referred to as 'occasions'. These include the metaphoric or symbolic use of blackness and the presence of behaviour such as theft, sexual licentiousness and uncontrolled emotionality, customarily thought of as deviant. 'Occasions', Faris argues, are a context for sanctioned deviance. Given the breadth of this very detailed material, which takes account of historical as well as contemporary perspectives, the full cultural and social significance of the behaviour of bereaved individuals in Cat Harbour can be appreciated. Of mourners, Faris says:

> ...their role is considered potentially a very emotional expression, and any overt emotional exposure is regarded as potentially dangerous and avoided in Cat Harbour. (1973:56)

It is thus that the exclusion of mourners from contact with the deceased and indeed with all everyday activities can be understood. At funerals they are spatially set apart from the rest of the congregation and from the 'helpers' (close outsiders who manage the corpse, the grave and the burial). With black ribboned lapels, mourners sit inside black ribboned-off space in the church. Helpers sit in a corresponding white ribboned-off space.

Faris limits the material presented in this paper to the structuring of immediate death ritual and its implications for the significance of emotional expression. Though cosmological considerations are not addressed, it is clear that the relationship between the culturally constrained emotionality of life and the emotional exposure thought inevitably to be precipitated by death is one of opposition. Such is the expected nature of grief that it cannot be encompassed within the category of experience 'life' but, along with other examples of sanctioned deviance, is set apart and framed within the times and spaces known as 'occasions'. Through imagistic or metaphoric references to blackness the concept of outsiderhood is evoked at all such 'occasions', thereby distancing and setting them in opposition to the acceptable sociality of the insider.

Clearly death and powerful emotion are associated, probably universally. Hertz begins his essay on death by saying:

> ...we all believe we know what death is because it is a familiar event and one that arouses intense emotion. It seems both ridiculous and sacreligious to question the value of this intimate knowledge and to wish to apply reason to a subject where only the heart is competent. (orig. 1907; 1960:27)

The material cited here places the 'intense emotion' associated with a subject 'where only the heart is competent' within the (cross-cultural) context of a whole range of emotionally expressive behaviour. In each of the three examples cited in this section an explanation of the principles through which the conceptual categories 'life' and 'death' are generated provides an initial entry into the material. From this perspective the details of who does or doesn't grieve, of how, where and when emotion is expressed can be seen to be both inspired by and also given meaning by the particular cultural/religious system in question. Death ritual itself can be seen as institutionalised, non-ordinary discourse through which the particular, the contingent and the spontaneous responses of quite specific survivors or groups of survivors may be given coherence. Informed by this view the structured significance of the individual's motivations and moods can be understood. Of this approach to what are often thought of as 'mental traits' or 'psychological forces' Geertz says:

> ...it gets them out of any dim and inaccessible realm of private sensation and into that same well-lit world of observables in which reside the brittleness of glass, the inflammability of paper and...the dampness of England. (1968a:26)

In summary, the focus of the material presented in this section has been the nature of the cultural categories through which death is framed. Ricoeur's distinction between explanation and interpretation is important to this discussion (1981:152-164). He argues that structural analysis is both necessary and limited from the point of view of interpretation, whether of text, myth or social occurrence. In each of the examples presented a system of cognitive categories has been elucidated. The analytic concepts of 'order' and 'disorder' come readily to hand when dealing with material associated with death. Yet as Ricoeur points out, a purely structuralist analysis stops a long way short of 'reality' as experienced by other human beings.

Certainly death raises cognitive dilemmas. Indeed Geertz cites death along with 'dreams, mental fuges, volcanic eruptions or marital infidelity' as anomalous events or experiences which human beings seek somehow to bring into line with the orderly predictability of everyday existence (1968a:15).

Structural analysis can perhaps best be seen as an initial, explanatory unveiling of the depth semantics, the deep structures or internal relations of a cultural system. Interpretation has as its focus the meaning-in-the-world or referential meaning of the system. In the last section of this chapter I will discuss the processes through which such a system takes on and creates meaning. As regards the present section, the following points have been established:

(1) that the biological event of death may be culturally elaborated in the form of opposed categories of experience 'life' and 'death'.

(2) that death ritual affirms the culturally-specific nature of that boundary, expressing on some level the twin concepts of separation and continuity.

(3) that conceptual categories in themselves have only an internal, self-referential or sense meaning. Their referential meaning concerns what they are 'about' in the context of society as a whole and arises out of their role as both an inspiration for and an interpretation of the quality of individual experience.

3 DEATH RITUAL AND THE QUALITY OF EXPERIENCE

In this final section I will give indications as to how death ritual provides both an inspiration for, and an interpretation of the quality of individual experience. I will discuss the way in

which power is evoked and brought to bear upon those involved in death ritual. In preceding sections I established the idea that death ritual is a cultural and social elaboration of a biological event and that emotion must be understood as a social rather than purely individual area of human experience. Ethnographic material has exemplified the variation in form and in content of death ritual, in other societies. What remains to be discussed is how ritual such as this works and here the idea of authenticity as an important aspect of death ritual must be reintroduced.

Current dissatisfaction with the authenticity of Western ritual forms leads back to an examination of the ways in which ritual does convince or inspire participants. The Western perception of 'religion' and therefore religious ritual at the time of death as a discrete category of experience has already been contrasted with the more overt coherence between death ritual and other aspects of life within some societies. Thus in the example of Du Boulay's work (1982) she shows how the relationship between the categories 'life' and 'death' is structured through the same principles or patterns expressed in marriage rules and dance. Okely's work (1983) shows the boundary between the living and the dead being used symbolically as an affirmation of the gypsy/gorgio boundary. A coherent circularity can thus be seen. The issues of life may be used metaphorically to give form to death whilst the event of death may similarly be elaborated in such a way as to affirm the validity and permanence of the issues of life. In the creation and re-creation of this circular process, some aspects of death as a biological event are highlighted while others are downplayed.

La Rochefoucauld has suggested that:

> Neither the sun nor death can be looked at with a steady eye. (orig. 1678; 1967:13)

His statement is about the role of metaphor in the human encounter with death. The eye, wavering in its glance towards the sun, is an apt analogy for the human encounter with death and indeed for the metaphoric process itself. La Rochefoucauld's statement is quoted on the title page of Hinton's 'popular' book, 'Dying' (1967). The choice of this statement indicates both the resonance of La Rochefoucauld's use of common experience, sun-gazing, to evoke the quality of a more opaque experience, the contemplation of death, and indeed the felt need for such analogies in areas of experience such as death.

The nature of metaphoric thought and expression has been the subject of extensive work. Lakoff and Johnson draw upon the ideas of Ricoeur and their arguements are particularly relevant to the present discussion (1980). Like Ricoeur, they question the perception of metaphor as a peripheral, poetic/ decorative linguistic flourish. Rather, the notion increasingly assumed within social anthropology is that most thought is of a metaphoric nature. Lakoff and Johnson argue that human beings do not experience and understand the world in which they live in a direct fashion but rather through an inherited system of culturally-specific constructs or metaphors. The authors identify two 'myths' which prevail within Western society, describing them as the 'objectivist' and 'subjectivist' myths. Though perceived in opposition to one another, both myths are consistent with the idea that:

> ...the world is made up of distinct objects, with inherent properties and fixed relations among them at any instance. (1980:210)

Informed by these myths, human thought and language is often seen is an immutable and direct response to such a world. Variation in human response is located within the individual, understood according to the subjectivist myth which is concerned with intuition, emotion or imagination.

As an alternative Lakoff and Johnson posit the 'experientialist' myth which asserts that individual experience may better be understood in terms of the rational, structured and creative metaphoric concepts through which human beings think and act within the world. 'Experientialist' describes the properties of such concepts, i.e. that they may be seen as a society's hypotheses about the nature of the world, tested through experience in the world and abandoned or elaborated according to their aptness, richness or usefulness. A hypothesis or metaphor of this kind describes some dimensions of a phenomenon in the world, for example love, work, death, highlighting certain aspects of the phenomenon, downplaying others. Death is an area of experience which more than most evades comprehensive metaphoric interpretation.

For example, it can evoke intense emotion; it can raise profound questions about the nature or meaning of life; and, furthermore, the nature of what it represents, beyond physical extinction, will remain mysterious. Given all this, the contemplation of death, like the sun, is an unsteady process, made possible only through elaborately conceived and persuasive metaphoric systems. This thesis describes acts and utterances which constitute a cultural and social response to death. They are the sets of lived metaphors through which death is being encountered. According to the view presented by Lakoff and Johnson, I will look at them as interpretations, as ways of seeing, which not only highlight but also downplay one area or another of the events and experiences associated with death.

Lakoff and Johnson's work implies the made-up quality of metaphoric systems. Truth is a contextual rather than universal matter and creativity is the hallmark of an inevitably incomplete metaphoric process. This brings discussion again to the question of persuasiveness and how one interpretation rather than another is experienced as a convincing description or re-description of

reality.

La Rochefoucauld's analogy of sun-gazing has been cited as a popularly quoted and therefore illuminating evocation of the encounter with death. Lakoff and Johnson use the term 'experientialist' in arguing that 'reality' is the experience which human beings create for themselves through their use of metaphor. I have described a system of metaphors as hypotheses or ideas about the world which are validated only through direct experience. However the term 'experientialist' also describes the origins as well as the continuing means of validating such a metaphoric system. Lakoff and Johnson show how very simple bodily experience often provides a grounding for conceptual thinking. Thus in statements such as 'I get a lift when I see you', or 'I may fall into a depression', intangible emotional experience is given form through metaphoric use of the basic 'up'/'down' orientations of the body. Gazing at the sun is of course, another example of a common physical experience which has been used metaphorically to evoke the experience of encountering death.

Thus, in asserting that metaphoric concepts have an experiential nature, Lakoff and Johnson are describing a circular process in which simple bodily experience in the world provides an experiential basis for metaphoric thought. That thought is then used to structure experience in the world thereby finding confirmation or contradiction of its authenticity. One metaphoric system, validated in this way, may then be used to structure another, for example in the Western cultural concepts 'time is money' and 'argument is war'.

Metaphoric thought can be described most simply as seeing one thing in terms of another. Lakoff and Johnson stress experience in the world as both a common source and a validation for this process. Returning to death ritual and the way in which it works, this approach is invaluable in that it enable us to look

in much more detail at the themes of authenticity and cultural consistency.

For example, Du Boulay and Okely's work (1982 and 1983) both show death ritual structured in terms of other aspects of a particular society, i.e. one thing, death, being seen in terms of another, a marriage pattern and an ethnic boundary. As I suggested earlier, the process does not operate in one direction only. Okely points out:

> ...the boundary between life and death is used to make symbolic statements about another boundary. (1983:230)

The limitations and the need for structuralist analysis have already been discussed at some length. Seeing or understanding one thing in terms of another can be brought about through structural similarities. This in part accounts for the nature of death ritual among both Greek villagers and gypsies. Nonetheless, as noted before, structuralist analysis is in itself limited. Ricoeur talks in terms of the self-transcendence of what are essentially the atemporal, semiotic units of material such as myths, ritual or any piece of social interraction (1978:74). Informed by Ricoeur's thinking, Lakoff and Johnson offer the term experientialist to describe this process of self-transcendence. In the examples I have presented it is bodily or in-the-world experience which can be seen as the basis of metaphors through which death is encountered, for example the flowing quality of blood; the body's visible and invisible surfaces; and the historical and geographical circumstances of a community. Used metaphorically these very immediate experiences allow other less tangible phenomena to be grasped and indeed to be manipulated. Such systems may then be used to make other possibly more abstract phenomena accessible to understanding.

Realised in thought, language and action, systems of this kind 'take place' within the time and space of everyday. In this way the process of self-transcendence occurs, as abstract schema, grounded in basic physical experience, resonate back and give meaning to that world from which their substance has been drawn. As Bourdieu says:

> ...the mind is a metaphor of the world of objects which is itself but an endless circle of mutually reflecting metaphors. (1977:91)

Thus meaning arises out of the being-in-the-world of events, speech or behaviour and it is to this broad domain that structuralist analysis provides initial entry.

The work discussed so far goes a long way towards showing how metaphor operates and, therefore, how it becomes persuasive. The metaphoric process has nonetheless been shown to be creative and inevitably incomplete. Ricoeur describes it as the bringing together of two previously unconnected ideas, a calculated error which re-describes the world in which it takes place (1978:21-24). Words themselves he refers to as 'metaphor(s) on the road to extinction' (1978:143). In this dynamic process all metaphoric systems are susceptible to change. In the highlighting of some aspects of a phenomenon, scope inevitably remains for the re-inventing of that which is downplayed.

How then, in ritual, does a society's fluid and possibly inconsistent metaphoric system come to be experienced as an unquestionable representation of wholeness or order ? Ritual takes place, by definition, in times and spaces set apart from the everyday world as understood and lived in through such metaphoric systems. Nonetheless it is potentially a profound influence within that world. Again a circular relationship is in operation. As I will show, ritual draws power through the appropriation of the material of everyday life. That everyday life, or rather the metaphoric system through which it is

experienced, may then find both validation and completion through the power and influence of ritual forms.

Geertz's discussion of the question of religious belief (1968a:25-26) is of particular relevance to this discussion. He argues for a relationship between belief and the acceptance of an authority which can transform experience. Believers are those who willingly become susceptible to the power embodied in a particular system. Through imagery, trance or charismatic personality, power of this kind may be expressed. A familiarity with recognisable ritual forms, by definition distinguishable from the secular, common-sensical world of everyday, and a willingness to submit to their power would seem to be essential dispositions in the believer. As I will show, an analogous context is the theatre. The fictional reality produced through stage sets, actors and musical or other effects is accepted and 'believed' by the theatre-goer. The quality of a performance is often judged largely by its power to uphold such an illusion. It should maintain the audience's unawareness of the rehearsed and carefully contrived nature of the fictive world in which they have elected to 'believe'.

In his published diary Frisch describes a chance experience of observing the unintentional framing of people and events within the stage's proscenium arch during the hour before a rehearsal (1950:63-65). He notes the transformation of trivial actions and objects when captured, fleetingly, in this space. Suddenly they acquire a 'non-ordinary' weight and significance. This leads him to reflect how eras and continents can be evoked at will within the finite, fictive time and space of the stage play. As each object, gesture or utterance is presented, it takes on expansive referential meanings which transcend the immediate physical world of actors and props. Offstage, for example, chairs are understood largely in relation to other household objects of the category 'furniture'. This could be described as the internal or sense meaning of a chair. Onstage, a chair can assume a vast

breadth and subtlety of significance depending, for example, on who uses it and how.

This example takes us a long way towards the heart of the ritual process. Both theatre and ritual are extra-ordinary contexts in which the material of everyday life can be made to demonstrate what Esslin describes as:

> ...the inherent symbolism of reality itself.
> (1982:10)

One actor or one object can stand for a whole class of men or chairs and can represent the essence of that class through its presence on the stage.

As already shown, many of the conceptual systems through which we perceive and experience the world are grounded in our bodily experience of that world. In a ritual context that relationship between abstract thought and physical experience is often inverted. Metaphoric allusions to primary biological experience, usually the implicit grounding of more abstract schema, are made demonstrably explicit. As Fernandez says:

> ...metaphors provide organizing images which
> ritual action puts into effect. (1977:101)

He draws on the example of the Indians of the North Pacific coast. He quotes Boas's comments on:

> ...the use of metaphorical terms in poetry,
> which in rituals are taken literally.
> (Boas:1911)

Potlatch, the large-scale consumption/destruction of material wealth is described by Boas as 'closely related' to the metaphor 'devouring of wealth'.

In summary it can be said that the experiential grounding of conceptual systems is an important aspect of their authenticity. As a rule the sources of common metaphors remain implicit, resonating back into the tangible, surrounding environment in a way which is largely inaccessible to the conscious mind. Indeed in making explicit the experiential grounding of metaphoric forms the work of Ricoeur and, in turn, of Lakoff and Johnson, has been profoundly innovative. The role of metaphor in the creation of meaning is anything but apparent. Thus, for example, Bishop Jenkin's explicit references to the metaphoric rather than literal role of the 'worldly' events which constitute the Christian gospels[6] have been seen as potentially disruptive to the religious experience of many believers.

When framed within ritual time and space, the revealing of the normally veiled, literal substance of conceptual systems potentially reanimates or revitalizes those systems in their capacity to describe or interpret the world. As noted, Moore and Myerhoff have drawn attention to the dangers inherent in this process (1977:18). In presenting the implicit grounding of metaphoric thought for view in an open and deliberate fashion the risk of revealing the made-up, arbitrary quality of that thought is of course incurred. It is nonetheless the concrete representation of organizing images which lends a sense of integrated wholeness to the believer's experience of the world and of themselves.

The framing of ritual time and space has already been noted as one crucial element in this process. In addition a willingness to believe, to submit to the power embodied within ritual forms is also critical. Moore and Myerhoff describe how knowledge is imparted through ritual in the form of postulates which:

> ...render it unverifiable, separate from standards of truth and falsity. (1977:18)

In his work on the nature of symbolic forms, Turner (1967:19-17) addresses the question of how power of this kind is embodied. He shows how literal representations of metaphoric images in a ritual context - a candle, a black ribbon, bread, wine - have a multivocal power. In this respect they are like the stage chair, flower or king, which transcends its own immediate self and is transformed into a representation of the essence of all chairs, flowers or kings. Central to Turner's approach is the idea that such objects, and indeed gestures, smells, music and the structuring of time and space, can all have an expansive set of referents ranging from the physiological to the most abstract areas of life. In other words conceptual schema and their experiential origins are brought together and fused. In this way abstract thought is reanimated by primary experience whilst simultaneously giving form and meaning to fundamental experiences such as birth, copulation and death.

Death itself is a good example of this process. It is commonly made use of metaphorically. In our own society its figurative use imputes an ultimate or extreme quality to the emotions or events of life. This is exemplified in expressions such as:

> 'dead centre'; 'dead on time'; 'I'm dying to meet you'; 'You'll die when you hear this'; 'I'm tickled to death'.

In other societies death is the image through which change or transition is understood. 'Deaths' are enacted in many rites of passage, particularly initiation.[7] It is in this process that Bourdieu's description of mind and world as 'an endless circle of mutually reflecting metaphors' (1977:91) is borne out. In our own metaphoric representations of death it is the biological finality of the event which is emphasised, for example 'terminally ill', 'on her way out', 'lost'. This in turn is reflected in our metaphoric use of death to lend an ultimate or

extreme quality to everyday happenings. In societies where images of transcendence and continuity are stressed at the time of death, we find a corresponding metaphoric use of death to suggest transition.

In describing how the literal and the figurative come to be fused, Turner talks in terms of the bi-polar aspects of all dominant religious symbols. Encompassing both the physiological/ emotional and the abstract/conceptual domains, such symbols can be so manipulated within the ritual context as to evoke any one level or area within the symbol's sphere of reference. Whilst the participant's attention is thus focussed, the broader sphere of the symbol's reference nevertheless continues to make itself felt. With the imagination, intellect and bodily experience simultaneously engaged, the participant's experience shifts continuously from partial to total awareness and understanding. In this way the possibly inauthentic and undoubtedly limited 'reality' of everyday life is not only re-presented as valid and unquestionable; it is also experienced as but a part of what Geertz describes as a 'correcting and completing' totality (1968a:39).

It is this experience of wholeness, made possible only through submission to the constraints of ritual time and space, which may be carried out into the less predictable world of everyday life. There the experiential sources of conceptual thought again become veiled. Having been revealed in the ritual context, their power to impute authentic meanings to experience-in-the-world is restored.

In ritual processes associated with death, at a time of potential chaos and incompleteness, the symbolic manipulation of objects, space and indeed the corpse itself, can serve to transform that present experience of confusion and loss by placing it within the context of a set of meanings which resonate throughout the entire cultural system.

Levi-Strauss offers the example of death ritual among the Bororo (1973:298-320). The permanent loss of a member of Bororo society is encountered in terms of the idea that death is the violation of culture by nature. This idea is given form in the reciprocal killing of a large animal by man. Once avenged in this way the spirit of the deceased is thought to be received into a society of souls. Such a society is re-created through dances performed by the male representatives of whichever tribal moiety the deceased was not a member. Levi-Strauss describes Bororo death ritual as 'a dazzling metaphysical dance'. He shows that it can be seen to 'correct and complete' the experience of an everyday world where separation and inequality predominate between moieties, clans and gender and where 'men die and do not come back'.

In summary, ritual can be seen as the literal presentation and manipulation of the set of metaphors through which death is encountered in a particular society. Within the framing of ritual time and space, everyday objects and familiar spatial and temporal arrangements are re-ordered, thereby evoking participants' most fundamental physical and emotional experience and bringing it into line with the most abstract cosmological theorising. It is through these processes of framing and re-ordering that the expressive symbolising power of objects/ events is maximised. Spanning both a biological and an intellectual plane, symbols create within the participant an experience which is not only authentic but also exclusive. Moore and Myerhoff use the word 'postulates' to describe the form of knowledge apprehended through ritual (1977:18). That is to say, the power of ritual is very much bound up with its capacity to exclude alternatives. Selectively highlighted aspects of experience in the world are transformed into a representation in which life as lived and life as imagined are fused. In such a context the inner turmoil of individual survivors' grief is given selective expression in images or outward forms which have

referents within the more expansive and more ordered world view shared by the entire society. It is in this way that death ritual provides both an inspiration for and an interpretation of the quality of individual experience.

4 SUMMARY

Discussion in this chapter draws on an anthropological perspective in order to put forward ways of thinking about the management of death. Such an approach has a valuable place within the growing critique of contemporary Western practices associated with death. Its special contribution is the reflexivity which comes from exploring our own approach to death as one possibility among many. For example, even the nature of and relationship between our most fundamental categories of experience, 'life' and 'death', can be seen as aspects of our own culture and society and not as universals.

Authenticity is a key area throughout the discussion of approaches to death. Those metaphoric systems which persuade or illuminate are experienced as authentic within a particular cultural and social milieu. Very often they constitute what is apparently most 'natural' or 'self evident' within the world view of a society's members. The ritual processes described are the means through which that which most belongs to culture is rendered most 'natural' and therefore authentic to the participant. Hertz's assertion that:

> ...when a man dies...society...is stricken in the very principle of its life. (orig. 1907; 1960:78)

raises the points that death not only calls existing values and assumptions into question but is also the occasion when ritual forms may be used to affirm or re-create those assumptions in the most authoritative and unquestionable manner possible. This has

led me into an initial discussion of the processes through which a set of meanings or interpretations come to be apprehended by society's members.

The discussion of fieldmaterial in Part Two of the thesis is informed throughout by this understanding of the metaphoric nature of human thought and experience. It demonstrates the processes through which such metaphors are manipulated - so constituting our own encounters with dying and bereavement.

NOTES

1. Most prominent among psychiatrists and doctors are Saunders (1959,1965), Weisman and Hackett (1961), Hinton (1963, 1967), Murray Parkes (1964a,1964b,1967,1972), Kubler Ross (1970,1975). Among sociologists Feifel (1959), Glaser and Strauss (1965,1968) and Sudnow (1967) have all made contributions to this field. Historians Aries (1974,1981), Stannard (1977) and Whaley (1981) are also noteworthy.

2. For example, the death of a leader has been a focus in the work of Tambiah (1976), Geertz (1974), Metcalf (1979), Frazer (1963), Evans Pritchard (1948) and Lienhardt (1961).

3. The Book of Common Prayer and Administration of the Sacraments...according to the use of the Church of England. A.R. Mowbray: London. pp. 213-216.

4. For example Gorer (1938) devotes less than twenty of the five hundred pages of his monograph to the question of death. Yet he himself notes that this is the area of greatest tension

between lamaism and the Mun religion, the two belief systems to be found within the Lepcha village. Similarly Chagnon (1968) offers only a brief discussion of the consumption of human ashes and the significance of endocannibalism among the Yanomamo.

5. For example mutual aggression persists between those of differing religious identities in Northern Ireland. In this context the possibility, even probability, of a violent death is a known dimension of promoting one's own affiliation. Similarly in South Africa vulnerable black communities seek determinedly to subvert harshly imposed, and limited, white definitions of the meaning of being black. Again a high risk of violent death is seen to be part of the process of change.

6. See David Jenkins, 'Fairy-tales and the Church'. The Observer, 23.12.84, p.8.

7. Turner (1967, 93-111) uses the example of Ndembu rituals of initiation to point out that the symbolic use of aspects of the human body, blood and nakedness, connote not only growth as in menstruation and birth, but also death as in killing and the corpse.

CHAPTER TWO

THE ANTHROPOLOGIST AS A TOTALISING AND SYNTHESISING THEORIST

Central to an anthropological approach to the management of death is the question of life and death as culturally and socially elaborated categories of experience. In the ethnographic examples of the last chapter the boundary between life and death was the focus of death ritual. An appropriate movement across this boundary is critical within rural Greek society where one of its key concepts, the idea of life-giving energy or vitality, is understood through images of an irreversible right-handed movement or flow. By contrast material from isolated or marginal social groups such as a Newfoundland fishing community and gypsies shows ethnicity to be a central issue. In these contexts the possibility of immutable conceptual, social and biological boundaries is given maximal cultural and social emphasis, particularly at the time of death.

I have selected ethnographic examples where the boundary between life and death is central to death ritual in order to introduce material from our own society, to be explored throughout the thesis. What I will demonstrate is that for us too the boundary between these two categories is critical. My demonstration involves looking, in turn, at examples such as the way spatial separations are introduced between living and dying; at the way a medical framing of this boundary has become critical; at the way 'death' has been made the province of distinct, often marginal social categories such as 'the elderly', 'the bereaved', 'the mortuary attendant', 'the funeral director'; and at the way language of a euphemistic or humourous kind is used to assert the nature of a life/death separation, to distance the future process of dying.

Thus, for example, home, the domestic context of 'life', is currently the place of less than 30% of all deaths.[1] When the North East Co-operative Society sought to convert its Washington store into a funeral parlour, local residents, councillors and the town's MP campaigned to block the plan. The Durham Advertiser[2] explained:

> An 80-year-old widow's ground floor flat on the Coach Road Estate, Washington is less than 20 yards from a newly-converted funeral parlour which is due to go into operation soon. From her kitchen she will be able to see hearses carrying coffins to the parlour's chapel of rest - formerly a Co-op store.
>
> Every time Ivy Stearman washes the dishes or cooks a meal she comes face to face with death.

Twenty yards was thus deemed an insufficient spatial separation between the business of living and the prospect of dying.

The identifying of separating rather than mediating boundaries of this kind can be seen as an initial, structuralist analysis of ethnographic material concerned with our own encounter with death. By bringing together examples from the domains indicated above, coherence within a whole range of boundaries is suggested. However an interpretation of such a state of 'coherence' rests not only upon detailed appraisal of each example but also upon the contextualising of the management of death within the management of life. This chapter sets out the principles and the methods selected in order to contextualise and therefore interpret field material directly associated with death. I will begin by discussing in more detail the anthropological perspective through which I am operating.

1 DOUBLE VISION

The developing of an anthropological perspective can be described as the cultivation of double vision. In Chapter One I stressed the reflexivity which is particular to social anthropology and which comes from exploring our own approach to death as one possibility among many. In other words the anthropologist locates themselves between cultures. This orientation allows for an awareness of the 'critical lack of fit' - from which Ardener describes the anthropological experience as deriving (1971:xvii).

In addition double vision encompasses not only the 'outsider's' view but also the perspective of the 'insider'. I use 'insider' not to refer to membership of the group among whom research is being carried out but rather to refer to the relationships which link all social categories or groups, all nations and continents, and ultimately, the Third World and the West. In other words the anthropologist is always, on some level, a part of the field within which they are working.

Within the thesis I am combining very broad historical and cross cultural perspectives (1.1, below) with detailed material from three quite specific field locations (1.2):

a) a residential home for elderly people in the North East of England.

b) a hospice in the south east of Scotland.

c) the North East branch of Cruse, a national organisation which offers support to bereaved people.

The vehicle through which a synthesis of this material is achieved is my own consciousness (1.3). In continuously embracing both perspectives the researcher develops a capacity

for double vision. The value of this practise can be further enhanced by drawing upon some of the more oblique perspectives offered by historians and social theorists, and by anthropologists themselves, each with respect to their own field.

1.1 The most global of global structure

In viewing the management of death from a broad historical/cross-cultural perspective I have drawn upon the work of writers who in some senses have moved away from the centre of their own specific disciplines. From this position theirs is a double vision of systems which form the subject matter of their discipline or of which they themselves are a part. In the work of Capra (1982) and Aries (1981) eras and continents are condensed.

Capras's vision as a physicist penetrates the limits of Western scientific models and shows their meeting point with an Eastern, mystic world view. In arguing for the presence of a continuum of understanding, currently masked by fragmented, culturally-specific bodies of knowledge, Capra re-appraises the changing modes of thought through which human beings in the West have perceived the world since the Middle Ages.

As an independent scholar, until recently without an academic attachment, Aries offers historical synthesis rather than analysis. His broad sweep encompasses literary, architectural and iconographic sources related to the management of death. Martins describes his use of such 'evidences':

> ...marshalled for their cross implications in order to construct 'meaningful totalities' for distinct historical periods. (1983:xv)

In seeking to make sense of the boundaries which divide life from death, and living from dying, the arguments put forward by Aries and Capra are illuminating. They write from an awareness of both the de-humanising isolation of the dying and the dangerous fragmentation of knowledge in the West today. As physicist and

as historian they offer interpretations of developments in ways of thinking about the management of death and the management of life in the West from the Middle Ages through to the present day.

Alongside the very broad perspectives offered by these writers I have also drawn on the work of social critics or theorists Illich (1975), Berger (1976,1980), and Sontag (1983). Grounded (jointly) in a variety of disciplines, theology, history, fine art, literary criticism, they each have addressed medical models of life, death and health, so unmasking the political implications of a 'scientific' framework. Like Capra and Aries they speak, revealingly, from the periphery, so illuminating the powerful models which represent the centre. This body of work, drawn from disparate sources, demonstrates the critical role of the 'outsider's' view within the double vision which is an anthropological perspective.

1.2 The most local of local detail.

Within the context of the work indicated above I am placing an account of members of contemporary Western society engaged directly in their own encounters with death. Its interpretation arises out of an intellectual activity described succinctly by Geertz as:

> ...hopping back and forth between the whole conceived through the parts which actualise it and the parts conceived through the whole which motivates them. (1977:491)

The anthropological perspective thus emerges as a doubling of double vision. The whole, that is to say the broad sweep, is offered by the 'theoretician' who writes from the periphery of their own sphere of intellectual interest. The parts, that is to say the events, the practises, and the allusions through which death is encountered, are brought into play through fieldwork, the grounding of social anthropology.

1.3 The inner arena.

As I will go on to show in more detail, the practise of fieldwork involves the bringing together of the whole and of the parts within the consciousness of the researcher. However distant the relationship between researcher and 'informant', the issues involved are, on some level, both about and also within the researcher. When the context of fieldwork is the researcher's own society and the topic is one which touches every one of its members, this point is particularly salient. Placing themselves in the position of intermediary between the specific and the more general manifestations of their sphere of interest, the researcher's past experiences and present responses are central to the processes of both participant observation and interpretation. In the act of 'hopping back and forth' the researcher also attends to that inner arena which is their own cultural and social world view.

Light is shed upon this process by anthropologists Burridge (1979) and Tambiah (1985). Like Capra and Aries they have been able to explore the nature of their own discipline by adopting the role of the 'outsider' in order to set an anthropological perspective within its wider context.

Burridge offers work on the dualistic character which the Western self has assumed since the initial emergence of Christianity. He shows that the tension between its two aspects, the 'person' and the 'individual', is integral to the pursuit of anthropology. Without the Western moral imperative that the 'individual' should stand aside from the 'person' in order to criticise and to re-create the categories of their own society, an anthropological perspective would not be possible. Burridge's perspective is discussed more fully in the next chapter.

Tambiah's discussion of the synthesising role of anthropology is grounded in Burridge's view of the moral implications of 'doing anthropology' - i.e. as a pursuit that exposes the categories of the world that is, thereby laying the ground for creating the categories of the world that ought to be. Thus Tambiah, in pressing for explicit demonstrations of the relevance of anthropological approaches, refers to:

> ...the role of the anthropologist as a totalising and synthesising theorist in a world in which specialisms spawn rapidly, to fragment and differentiate knowledge into realms, which are incapable of being interrelated in a coherent overarching cosmology. (1985:356)

His words can be nowhere more relevant than within the still separate, differentiated spaces where the vexed relationship between death and life is the explicit focus or the underlying orientation of all activity. He argues that it is the task of social anthropologists today to seek to reveal and also to act within:

> ...a world in which specialisms spawn rapidly.

Tellingly the example selected by Tambiah to illustrate his points is the bio-medical paradigm of disease and cure (1985:353-357). He cites the dislocation of human beings and their (social and cultural) environment as the outcome of a powerful prevailing model which, in allowing for dramatically effective cures, reduces human beings to material entities.

With respect to anthropology and its grounding in fieldwork I am therefore demonstrating the possibility of an understanding which arises out of a synthesis of both the immediate and the more pervasive dimensions of the human encounter with death. Just as a feminist critique of society becomes persuasive only when all aspects of women's experience are brought together and explored,

so too an understanding of the principles through which death is currently managed involves the assembling of very disparate examples of death-related experience. In a case such as the efforts made within the framework of the Women's Movement to transform an excluding, male-oriented emphasis in contemporary language, the issue can appear to be 'petty' or 'trivial' until the cultural and social context of such language is also re-appraised.

Whilst the commitment to an anthropological perspective may not imply a single and overt political orientation, its practise is inevitably subversive of existing cultural and social categories - and therefore strongly suggestive of ammendments and transformations leading to the creation of a world that ought to be.

2 RESEARCH METHODS

As I have suggested, an anthropological perspective, requires that I work within rather than on a particular field, a stance which is critical to the entire project. Traditional research methods are grounded in the separation of researcher and researched which creates a relationship of observer to object between the two parties. The discussion of Lakoff and Johnson's work (1980)[3] highlighted both the 'objectivist' and 'subjectivist' myths pervasive within the West and consistent with the ideas that:

> ...the world is made up of distinct objects, with inherent properties and fixed relations among them at any instance. (1975:171)

In keeping with this idea is Okely's argument that the traditional means of ensuring 'objectivity' is to eradicate the link between researcher and researched (1975:171). This can be achieved through the use of pre-determined sets of questions.

Extensive sampling is similarly effective in that confrontation between researcher and researched is mediated by large groups of assistants who generally do not design or modify the questionnaires, or analyse the data. As an alternative to precluding the possibility of a subjective response on the part of the researcher through the use of such distancing techniques, Okely advocates that the researcher cultivate an awareness of their particularity as a cultural and social being. In this way the significance and the implications of their own responses can be properly understood and made use of in subsequent interpretation. In the course of this thesis it will be shown that common sources can be traced for both the pursuit of detachment and objectivity within the social sciences and also the cultural and social strategies of distancing through which death has been managed. By working within the field of death-related experience in such a way as to overcome the observer/object relationship it becomes possible to construct the kind of knowledge which both reveals and repairs the schisms through which death is currently being managed in the West. In adopting such an orientation the researcher places themself within the broader processes of innovation and change which are taking place concurrently.

Thus the thesis is grounded in field material which reveals the management of death through well established cultural strategies of distancing and control. At the same time it encompasses the processes through which such strategies are currently being transformed. These include the Hospice Movement and bereavement counselling. In itself therefore the thesis can be seen as work which takes place in synchrony with innovations in fields associated with dying and bereavement. Moreover, in its method, it resembles these developments, in that it represents an holistic alternative to the objectifying and fragmenting approaches through which problematic and disordering areas of human experience are managed (in both a direct and an academic sense). Tambiah urges that the offer of this alternative must be

made, quite explicitly, by social anthropologists. Thus he refers to:

> The tendency to create special domains with their own logics by the process of atomisation of information (which) has simultaneously and paradoxically produced more gaps and holes in knowledge, even while it grew. (1985:352)

He goes on to say:

> Moreover, in the human sciences, the pretence that the observer is divorced from the thing observed does not accord with the fact that human consciousness and social representations are their ultimate subject matter, and the realities they deal with are the products of intersubjective interactions and conventions created in an open-ended historical process. (1985:352-353)

This chapter thus argues for the use of the reseach methods discussed above specifically through a description of the processes through which the thesis has been constructed.

3 THE CONSTRUCTION OF THE THESIS

My personal involvement in the field of death-related experience is the vehicle through which the thesis has been produced. It is an involvement which encompasses my own 'death history'; the thoughts, feelings, actions and choices which represent my responses to such a field; the responses evoked from the individuals who aged, died and/or were bereaved in the course of the work; and the responses evoked from the 'supporting cast' of care assistants, counsellors, nurses, doctors, friends and family. What I have written arises out of an extended dialogue between myself and these individuals. Whilst at times the 'dialogue' took the form of explicit exchanges or conversations, it is, essentially, an implicit process of negotiating a shared encounter with the idea and the event of death.

The fieldwork which I undertook is of a kind familiar to any social anthropologist. That is to say I made choices about appropriate field locations (a residential home for elderly people; a hospice; and an organisation supporting bereaved people), I sought entry, a role and a modus vivendi within each context. Predominantly I bathed and fed people who were very elderly, I provided transport for people who were dying, and I counselled people who were bereaved. And, in the established manner, I wrote daily fieldnotes of as extensive, detailed and descriptive a kind as possible.

However, it is within rather than as a result of the flow of such visible activities that knowledge about our own encounter with death was constructed. Rather than a series of findings which, if the quality (and quantity) of field material is good and sufficient, can be extracted from the final sum, I am offering the outcome of a protracted intersubjective process. It is my entry into the imminent, immediate or remembered experience of others which opens up a wide range of choices both for other individuals and for myself. These choices range from that which is pursued or avoided on either side, to that which is expressed as an open emotional response or revealed only covertly through the body. It is the retrospective re-tracing of the direction or, more often, the twists and turns of choice that can be described as the process of unravelling the shared cultural concepts through which all concerned are encountering death. Examples of cultural factors which strongly influence these choices are the desire not to precipitate an overwhelming emotional response on the part of the other or of the self, the wish to actively reduce another person's suffering, the commitment to knowing about another's experience, the process of discriminating between more or less relevant disclosures or opportunities. Each of these factors must be recognised as an aspect of one particular cultural milieu. Each one of the individuals involved in the dialogue/research process is managing

their own mortality through similar sets of constraints or possibilities. I am distinguished among them not as an observer or a self-elected participant - I am distinguished from them primarily through my additional commitment to recording, exploring and elucidating what we are all doing.

In Part Two of the thesis I will present the outcome of such dialogues which took place among people who were rapidly approaching or had recently been approached by death. At present I am, to my knowledge, suffering no terminal illness, neither am I recently bereaved. This is not to say that I do not have my own particular death-related past, present and future. Indeed it is my own history which provides an entry into the cultural and social context within which fieldwork has been conducted.

4 PERSONAL HISTORY

Three personal experiences have been particularly influential in generating and sustaining my involvement with research into the management of death. They provide a frame or backdrop within or before which I have operated. The thesis provided a provisional closure to the frame and, as such, leads me, by a circuitous route, back full circle to a re-appraisal of important parts of my own autobiography. I have selected only three experiences. Doubly relevant, they provide additional, preliminary case material in that they illustrate the processes of distancing and fragmentation through which death has recently been managed. Moreover, in being reproduced within the thesis, they exemplify a growing movement towards re-assessing contemporary practice and exploring more integrated sets of responses towards the event of death. Whilst a full exploration of my own thoughts, feelings and experience with respect to death is beyond the scope of the present work certain events effectively crystallize whole areas of personal experience and illustrate its broader cultural and social significance.

(1) In 1955 my 74 year old grandfather was admitted to hospital from the tiny family home where I had always lived with him, my mother and my father. Suffering from heart trouble he remained in hospital for more than a week. Though I sent in cards and presents for him, as a 9 year old child I was excluded from visiting. Within ten days of his admission, whilst lying awake in the living room where I slept, I overheard my father anwering the front door. His **"Oh Lor!"** and my mother's unusually firm squeeze as they left the house evoked no conscious suspicion on my part - but I remember them still. The following morning, seated on either side of the kitchen fireplace, my parents announced my grandfather's death. Straight-away I began crying. Then, being told **"Don't cry. Grandad wouldn't want you to"**, I stopped, permanently. Soon after I spent the day with family friends, a special treat. Everyone else went to his funeral. A barely used toothpaste tube, the cards and the presents made a slightly disturbing re-appearance in the house. For nine years my grandfather had been by the kitchen fire, my sometimes frightening story teller and my solid climbing frame. Closer and more consistently accessible than either parent he made a rapid, invisible and emotionally unremarked departure.

(2) In October 1966 my mother, apparently healthy in her very early fifties, announced that she had to go to hospital, **"just for tests"**. Her concern that I might be worried surprised me - I wasn't. Within a fortnight my father appeared in the library where I worked to pass on, rather publicly, the doctor's announcement that she had ovarian cancer, that there was no hope, that she would die within nine months. Our decision to withhold the diagnosis from her was easily reached. Her unchanged manner and appearance gave a lie to the shocking information we were concealing. Its impact remained but was oddly dulled. We assimilated it privately as she, slowly, deteriorated. Our long held expectations were fulfilled the following March. When my father woke me to announce, **"She's just gone"**, my emotional response was minimal. Whilst the sound of her coffin bumping on the narrow stairwell walls remains in my memory I can recall no powerful feelings. In so small a house I somehow managed to see neither her body nor her coffin. It appeared later, from the back of a hearse, but as the focal point of a minimal crematorium service it evoked little more than an odd feeling of headiness.

(3) In May 1977 a phone call brought news of the sudden death of one member of a recently acquired circle of friends. In his mid-thirties the friend had died with the impact of a head-on car crash. In the weeks that followed a lack of appropriate experience became evident among many members of his social circle. While some were able to approach his widow, many failed and very few were familiar with the range of emotions she experienced. Similarly the offering of funeral wreaths was a gesture fraught with uncertainty about what to give and where and when to give it. Letters of condolence too were attempted, re-attempted and then abandoned.

A crowded country church and a winding procession to a hillside graveyard provided an evocative setting for such an encounter with death. Yet the young man's widow followed his coffin to the grave in white linen rather than sombre black. Afterwards she offered a sunlit funeral tea which parodied a long preceeding sequence of night-time parties. In his physical absence bemused mourners recreated the context of the young man's social life. Food and drink were laid out just as before and embraces were exchanged on all sides. The pattern was disrupted merely by the timing, the sunshine rather than darkness, the children rather than adults party-dressed, and now bicycling on the lawn. Only through such incongruities could the true nature of the young man's absence be grasped at. Then in the second year of a degree course in Anthropology I shared the uneasiness of this experience. On many levels I was perplexed. Other people in other places operated through systems which apparently provided more expansive answers to the questions raised. At this point in my personal history I had already begun to acquire the vehicle through which to approach and unravel such an enigma.

Events (1), (2), and (3) are scattered across twenty years of my life. In many respects they differ from one another. Event (1) reveals the practice of creating a boundary between the social category 'child' and the category of experience 'death'. In my case this was achieved:

(a) through hospital regulations which ensured a spatial boundary between my grandfather and myself.

(b) through my parents' withholding of knowledge.

(c) through effective parental control over my emotional behaviour.

(d) through funerary practice which routinely excluded children.

Event (2) illustrates the practise of maintaining a boundary between the individual and their own death - i.e. a diagnosing physician releases knowledge only to a close relative who in turn withholds that knowledge from the dying person. In maintaining this boundary other sets of distances are created. Thus:

a) the dying person is separated from close family in that customary openness towards them is withdrawn.

b) close family, in making a separation between personal feelings and visible behaviour, are cut off from their own emotional lives. Emotive stimuli (corpse, coffin) then are avoided.

c) funerary practice diffuses the reality of death and the emotional response of survivors.

Event (3) describes the attempts of individuals to transcend a carefully maintained boundary between life and death - and illustrates their difficulties. These can be seen to arise from:

a) lack of experience of bereavement in young adults (in the period 1911-1915, 33% of all deaths took place before the age of fifteen. For the period 1976-1980 this figure is only 2%.[4])

b) associated lack of funerary experience.

As a result those events and actions through which a sudden death was managed brought to mind a past social life more readily than a present physical death.

When these scattered and rather different events are brought together and viewed from an anthropological perspective, they show a consistent and coherent cultural strategy for managing deaths. In social discourse within the family, among the medical profession, and in funerary practise, a separating and excluding boundary between life and death was being maintained.

In the course of the second world war both my parents had moved considerable distances from their places of birth/extended families. Two world wars had left my father bereft of one half of his immediate family (father and brother). Educated from an early age in a boarding school for the orphaned children of drapers he too went on to work as a salesman in the retail trade. When my mother's paid employment ceased at my birth his was the only income in a household of four people. Her broad interest in spiritualism took the place of any family involvement in institutionalised religion - and indeed its practices were viewed with suspicion. Social and financial resources were therefore minimal and the management of two family deaths is in keeping with a very private, cautious and restrained way of life.

As their only child I grew up as the object of considerable emotional investment during the expansive years between 1950 and 1970. Education was prominent among the cultural and social developments of the time. My eventual university entry as a mature student and a parent in the mid-1970's is rooted in that period. Concurrently the very early 1960's are cited by Richard Hillier (1983:320) as the time of 'a rash of outstanding publications' about death and dying. Sociologists Glaser and

Strauss (1965;1968), and Feifel (1959) were publishing alongside doctors and psychiatrists such as Saunders (1959;1965;1967), Murray Parkes (1964a;1964b;1972) and Hinton (1963;1967). Their work was the first indication of the innovations of the late sixties onwards when numerous hospices and bereavement support organisations were to emerge. When my mother died in 1967 I was living in a family context where religious and close social networks were lacking - and where a very traditional post 11+ Grammar school education was highly valued. I turned to a book, 'Dying', published that year in Pelican edition by a psychiatrist John Hinton. Thus, as I emerged, confused, from a secretive six months culminating in the unseen removal of my mother's body from my home I found, in popular edition, a book addressed to:

> ...defining the known boundaries of acceptance and distress. (cover notes)

Hinton, it asserts:

> ...sets out to give a balanced, truthful picture of how people approach death in our post-war society. (1967:9)

Five years later, in 1972, another psychiatrist, Colin Murray Parkes, published 'Bereavement', a book addressed to:

> ...unravelling the problems of grief and mourning.
> ...furthering our scientific understanding of grieving.
> ...trying to develop means whereby bereaved people can be helped.
> (1972:Foreword)

Further involved in an academic education I turned to this book in 1977 on the sudden death of my friend (Event 3). Thus the apparently separate strands of my personal, family and social life, my educational career, the deaths I was encountering and the academic and psychiatric work in death-related fields can all be seen, over time, to become entwined. Lead by my academic

interest I subsequently became involved in bereavement counselling for Cruse, an organisation supporting (predominantly) widows and widowers. In the 1970's/80's the steady popularising of academic and medical material, coupled with the emergence of published accounts of personal experiences of dying and bereavement,[5] inspired many women whose energies might otherwise be directed towards local charity work to become similarly involved. Their backgrounds varied though personal experience of some kind was often a common thread. They include widows, clergy wives and older women seeking community involvement after their children have left home. The formation of new branches of Cruse and a widespread demand for training in bereavement counselling lead me, in 1984/85, from my initial academic interest towards a more personal involvement in teaching/organising roles within my own community.

My descriptions of the excluding protective strategies of my parents and later, inevitably, myself reveal their almost breathtakingly cruel edge. The control of suffering through the avoidance of experience invariably involves a diminishing of the self. Nonetheless my personal experience is unremarkable. My nine year long academic involvement in this area might suggest a quite special, unresolved personal difficulty - that is until my work is located within a growing body of research and activity similarly oriented towards re-appraising past practice and personal experience associated with death. Working as an anthropologist I have returned repeatedly to the same boundaries which separate me from my grandfather, my mother, my friends and therefore my own feelings of grief. I recognise them afresh, albeit in 'institutional' rather than purely 'private' forms. My research methods are grounded in questions concerning the role of boundaries in transforming or mediating related spheres of experience. Many others, feeling themselves or those around them to be similarly diminished, have addressed these same boundaries in roles such as psychiatrist, doctor or counsellor. Whilst I have described the management of three bereavements of my own,

their actual occurrence is in some ways irrelevant. While an individual may cite one particular bereavement as critical to the quality of all experience that follows, more powerful and pervasive still are the cultural frameworks through which human beings are perceived as divisible into separate physical, emotional, social and spiritual components - and human suffering is thought of as a problem to be removed or avoided.

5 ENTERING THE BOUNDARY BETWEEN LIFE AND DEATH

Having argued that my death history, the product of a particular cultural milieu, is inseparable from the history of my fieldwork. I will discuss my passage through the death-related experience of others. The boundaries through which I was excluded from death(s) in the past re-appeared at the very outset of fieldwork. Thus the individuals I wished to approach as 'informants' were themselves separated off in their passage from life to death or, when bereaved, in their passage from death to life. Just as in the case of any exotic field setting, entry into those carefully distanced categories of experience - ageing, dying and bereavement - required sensitivity and courage. Whilst these categories were in many ways unfamiliar to me, their foreignness stemmed from cultural strategies of distancing and control which were deeply imbedded within me.

In an initial dissertation (1978) I moved from my own experience into the similar histories of others. Conversations, largely with members of my own generation and social class, yielded material which corresponded closely with the details of my own past. A setting out of numerous death histories established a pattern of childhood exclusions, adult silences and prevailing uncertainty if not uneasiness with respect to the anticipated death-related experience of the future.

Whilst the cultural strategies of distancing and avoidance became evermore evident, the material was ultimately limited. Permeated by gaps and silences it gave insufficient insight into the ways in which such boundaries might operate when dying itself was particularly imminent. The full impact of the deaths which had approached me and others of my generation had, in many cases, been deflected. I needed to seek out social categories or areas of experience more intimately associated with death. With the intention of a closer encounter with death, I went on to make fieldwork choices which are, in themselves, revealing. In electing to approach death I sought it in its well-ordered context of old age. Any exposure to the unpredictability of human mortality was minimised in my choice of very elderly people whose timely dying was managed through the practised care of a residential home. Significantly I made choices in keeping with the prevailing assumption that mortality, when postponed sufficiently, becomes acceptable. Those who had avoided 'tragic', 'premature' or 'wasteful' death were, I assumed, the informants who, at that more appropriate stage of life, lay beyond the strategy of avoidance through which younger people managed their own untimely brushes with mortality.

Only with time was I able to trace the veiled structures of separation and control which, in the condensed living/dying spaces of a residential home allowed for the maintenance of a still critical boundary between the two categories of experience. Living closest to death (and the dying) residents'experience was among the most telling in that the minimal spatial and temporal boundary between life and death was given maximal cultural and social emphasis.

Only through further fieldwork in the roles of bereavement counsellor and hospice volunteer did I encounter the death-related experience from which so many individuals remain separated. The anthropologist returning from the political,

medical and environmental dangers of non-European fields readily inspires a sense of awe among less travelled companions. My passage into the experience of those who grieve - either for their own imminent death or for the recent death of someone close - evoked a set of parallel responses which range from bewilderment to embarassment. The analogy of a daunting political/geographical boundary effectively suggests the entrenched nature of the separation which is maintained between death and life.

With an awareness of the nature of this boundary and a role as hospice volunteer or bereavement counsellor, I found entry into this 'space' possible. Once broached the topic of death, like the boundary itself, became less intractable. Its capacity to inspire both paralysing depression and highly volatile emotion is nonetheless not to be underestimated. Passage within or across this space was made only cautiously, both by my 'informants' and by myself. Unknowingly all concerned would repeatedly sidetrack issues and deflect powerful feelings. As the encounter slowly progressed numbness, frustration and boredom were often experienced. Tears rarely fell without a painful struggle to withhold them. The black barbed humour of those who were dying was matched by the side-aching bursts of hysteria with which I, together with other 'helpers', would be overcome.

The material which I have brought back is both distressing and disturbing. The shock which it can produce within the reader is a response which confirms the pervasiveness of a cultural commitment to keeping death under wraps - or at the safe distance of old age. Indeed my discussion of those innovative movements oriented towards restoring a sense of wholeness and continuity with respect to dying and bereavement shows that the expanding of human experience into each and every painful area is an immensely demanding, if life-enhancing project.

6 SUMMARY

My first steps towards the role of the totalizing and synthesizing theorist have been taken in the preceeding discussion. Chapter Three offers a broad discussion of the extended historical processes through which specialisms have spawned and knowledge has been fragmented and differentiated. The more modest focus of this chapter has been the cultural/historical processes within and through which this thesis has been produced. Thus I have drawn together strands of my own autobiography, placed them within their cultural and social context, and shown their relationship with changing approaches to the management of death. In revealing, rather than concealing the personal experiences which have lead me to my present academic, social and emotional position I have argued for research methods which allow a pervasive cultural bias towards 'objectivity' within the social sciences to be overcome. By locating my autobiography and my 'subjective' responses sociologically I have placed myself within the broad sphere of experience I am exploring. This approach is then extended in fieldwork which involved my participation in the lives of individuals who were ageing, dying and grieving - and in the lives of those who cared for them. I learnt not by asking the direct questions of an uninformed outsider but by listening and responding to my more experienced fellow insiders.

This approach is appropriate and valuable in both a specific and a general sense. As I have indicated, my specific 'field', the category of experience 'death', is managed through cultural strategies which minimise the cognitive and emotional involvement of individuals in the biological processes of dying. This is in keeping with the pervasive processes of fragmentation which, broadly, constitute a Western world view. In such a 'field' context the integrative, synthesising approach of the social

anthropologist offers a powerful alternative perspective in the absence of which the social scientist merely replicates and remains constrained within these selfsame boundaries.

From the specific category of experience 'death' to the broader question of research within the social sciences the same holds true. As Tambiah argues, for anyone working within this field:

> ...human consciousness and social representations are their ultimate subject matter, and the realities they deal with are the products of intersubjective interractions and conventions created in an open-ended historical process. (1985:352-353)

Thus the generative principles of the intersubjective open-ended process called social discourse can be discovered only within the flow of events, speech and behaviour through which it is constituted.

NOTES

1. Mortality Statistics: Review of the Registrar General on Deaths in England and Wales, 1984. DH1 No.16, page 14. Office of Population Censuses and Surveys, HMSO: London, 1986. See Chapter Four for summary of table showing place of death.

2. Durham Advertiser. 27.10.78.

3. See Chapter One, pages 27-32.

4. Mortality Statistics, 1841-1980. Serial Tables. Office of Population Censuses and Surveys, HMSO: London, 1985.

5. These include Lewis (1961), Blaiklock (1980), Zorza and Zorza (1980), Leach (1981), Taylor (1984) and Long (1985).

CHAPTER THREE

FRAGMENTATION AND FLOW - A HISTORICAL PROCESS

The management of death in Great Britain today is currently a focus for members of a variety of academic and medical disciplines. Their work, like my own, stems from a period within which the management of death has been consciously reflected upon. The integrative research methods of the social anthropologist have produced the idea that the categories of experience 'life' and 'death' stand, currently, in sharp distinction from one another (Hockey 1985). Material from the popular press to be presented in this chapter indicates that they are separated from one another by boundaries which have come to be seen as causes for concern. Martins summarises recent social criticism of the management of death in the West under four headings (1983:xi-xv). He includes the medicalisation of death which introduces technology and beaurocracy into an intimate area of human experience; the de-ritualisation of death which involves both changes in existing liturgy and the broad process of secularisation; an impoverished social discourse and a diminished expressiveness of language with respect to death; and a sense of meaninglessness engendered by the lack of any coherent philosophy of life.

Appropriated by a specific (medical) social category, managed in separate 'medical' spaces, dying is no longer perceived as a domestic practice or event. Death, as an idea, is similarly made inaccessible through the lack of expressive linguistic or ritual vehicles.

Yet death remains close at hand - in graphic news-reporting; in drama and documentary; in the publications and broadcasts of both professional 'carers' and bereaved individuals; in the jokes and the metaphors of everyday life; and in the domestic sequences of short-lived family pets.

Just as a marginalised, controlled and diminished 'world of nature' is made accessible in zoos, circuses, safari parks and wildlife films and books (Berger 1980:1-26), so a transformed death is experienced through news items, dramas or personal testimonies which enter the home via letter-boxes and television sets. Illich describes Western religious iconography of the fourteenth century where king, peasant, pope, scribe and maiden each dance with their own mirror-image corpse (1975:124-126). Imaged in this way death was conceived as the indwelling, immanent condition of every human life. Through the historical processes to be discussed in this chapter such images and conceptions have been transformed - and death, like 'wildlife', has been secured in its position on the margins of current thought and experience. What I will show is that the fluid bodily processes which link life to death have been downplayed and the changes associated with growth have been separated from the changes associated with decline. Growth, an unbroken cyclical process, has undergone shifts of meaning and now refers to an infinite accumulative process known as 'progress'. Weber[1] compares:

> ...the individual life of civilized man, placed into an infinite 'progress'.

and

> Abraham, or some peasant of the past (who) died 'old and satiated with life' because he stood in the organic cycle of life.

Ethnographic material from more traditional societies shows how the tension inherent within an enduring social order which is constituted through ephemeral human lives may be managed. In the West, adulthood, a transitory phase of life, is metaphorically transformed into state rather than process. Rather than the enduring roles and statuses of the social order, it is adulthood which predominates as a state of fixed social and biological

stability attained by the individual after a youthful succession of carefully celebrated birthdays. This chapter explores 'progress' as an accumulative rather than cyclical process, one which rests upon the consistent marginalising of the experiences of decline, deterioration and loss.

1 THE TIME OF A LIFE

As I have suggested, the framing of the individual and the conceptualisation of time are themes apparent to some extent in death ritual everywhere. At issue is the relationship between the prevailing cultural and social aspects of human life and the human being as a single biologically ephemeral instance of the species. The death of a human being begins to take on meaning according to the way in which their biological finiteness is conceptualised in relationship to the more permanent nature of ideas, practices and non-living objects. It is out of the paradox that concepts such as stability, permanence or immortality can exist only in the minds of transient biological beings that meaning begins to be constituted.

Thus Ricoeur, discussing the concept of time, argues that it is only within the individual that (simultaneously) past time may be remembered, present time be attended to and future time be anticipated (1984:8-26). If this argument is accepted then the fundamental temporal ordering, locating or contextualising of human experience in relation to past, present and future is in fact an attribute of a transient biological being for whom past time expands as future time shrinks. The encounter with death is about the transition away from a balanced position with respect to the remembering, attending to and anticipating of time, and towards an imbalanced position in which a worldly future ceases to exist and the past, being no longer amenable to (future) reworking, takes on a new static and enduring quality. Thus time, as a fundamental cultural mechanism through which a sense

of balance or orientation may be achieved can itself be located nowhere but within society's mortal members whose position with respect to past, present and future is not only fluid but also, essentially, unpredictable. The paradoxes intrinsic to this state of affairs have been variously addressed or managed at different times and in different places.

For example, a comparison between sixteenth century and twentieth century practice in this country reveals two opposed strategies for managing the impermanence of an individual's 'future'. As the dying human being, the former nexus of past, present and future, ceases to be continuously transformed into their (worldly) future self and, instead, is permanently transformed into an element of the remembered past of others, so their awareness is, in the first case, brought to bear upon this paradox and, in the second case, deflected.

Thus from the sixteenth to the eighteenth century dying was thought of as an active practice and described as an art in manuals known as Ars Moriendi which were sold widely in this country. This evidence of the sense of personal responsibility felt by individuals for managing a rapidly dwindling 'future' has parallels in folk practices enabling the individual to divine the mortal or treatable nature of their illness. Compare the reluctance with which terminal diagnoses are currently communicated to cancer patients in this country. Attempts to retain an elastic 'future' prevail even when a well advanced fatal disease reveals its pressing boundedness. These attempts range from forms of rigid denial such as the deliberate planning of holidays and purchasing of new clothing, through evasive responses such as 'Never give up hope !', to a softening or redefining of the nature of time as in Hospice Movement literature where time is described as 'a question of depth not length'.[2]

These cases illustrate two very different ways in which the transformation of a balanced past/present/future triad may be managed. The tension between the transience of the individual and the relative permanence of culture nonetheless remains. Whilst ethnographic material from more traditional societies exemplifies the management of this tension, Western society must be seen as a special case, a particular departure from previously established ways of perceiving this paradox.

2 THE EMERGENCE OF INDIVIDUALITY

Burridge offers two terms, 'person' and 'individual', to distinguish between the culturally prescribed roles, duties and sentiments of one of a society's members (the person) and the actual choices and resulting experience which any one member of the society (the individual) may select (1979:32-52). A third term, the 'self', describes the capacity of the human being to move back and forth between the person and the individual and to (dis)integrate the two in such a way that their individuality is realized. Within our own society, in those contexts where any movement between person and individual is severely constrained, or the two are powerfully in tension with one another, the question of individuality will be pressing. The three 'field' contexts encompassed within this thesis (residential home for elderly people; hospice and individual bereavement) are, as I will show, important examples of this case.

Burridge's terms are useful in that they suggest the possibility of a separation within the self, one which allows for an initial distinction to be made between the more enduring nature of personhood and the inevitably transitory nature of the individual. In more traditional societies it is through the elaboration of such a possibility that the problematic transience of society's members is managed.

Introducing their collection on death and the regeneration of life Bloch and Parry discuss the deliberate confusion of cyclic and unrepeatable time in non-Western societies where the social order is conceived as eternal (1982:9-15). Control over the moment and manner of death is one way of stressing the cyclic and repetitive nature of (social) time. Thus for the Hindu ascetic, the use of death as a metaphor for initiation and change is given maximal literal expression. His initiation and funerary rites are one and the same ceremony, performed by him, and followed by a 'life'/'death' as a wandering ghost. By contrast the 'death' of the Hindu householder only takes place mid-way through cremation when their skull is cracked open by the chief mourner. In these cases the unpredictability of biological death is effaced through practices which allow for the culturally controlled release of life. Similarly among the Bolivian Laymi, the Lugbara and the Merina of Madagascar, there are separations of some kind introduced between the unrepeatable events of the individual's life and death and the cyclic processes through which the social order is replicated. Another example is the Southeast Asian practice of double obsequies, the focus of Hertz's work (orig.1907; 1960). Here the first disposal is associated with the perishable body of the individual and the second with the permanence of the social order expressed through symbols of regeneration.

Geertz explores the implications of separations introduced within the concept of the self, using ethnographic material from three social contexts (1977:483-491). He describes 'the never changing pageant of Balinese life' where titles and kin terms of every kind indicate an enduring system of fixed roles and status played out to infinity by a changing sequence of mortal human beings. He includes Morocco, where selfhood is a stable because private concern maintained in separation from a fluid public individualism. Individualism is defined only contextually through sets of relative terms drawn from the wide range of

tribal, linguistic and religious origins from which individuals stem. Geertz also points to Java where the individual is understood to be merely the transient meeting point of sets of inward feelings and outward actions both of which pervade and endure beyond the limits of the individual. Conceived in this way the Javanese individual is an essentially ephemeral phenomenon. This, coupled with an emphasis on the refinement and control of emotion and gesture, produces a profoundly muted response to biological death. Geertz describes the set smile and formal apologies of a young Javanese man recently, and suddenly, bereaved of a wife who had been central to his life since childhood.

In our own society, following Burridge's argument, the tension between the permanence of culture and the transience of human beings is encompassed by a particular, Western, concept of the self. Indeed the negotiating of such an opposition or tension is understood in the West to be constitutive of the self. This can be compared with the ethnographic material above where the ephemeral nature of the individual is made explicit, their passage through society being held secondary to the enduring status of the role they have inhabited as a person. In the West the individual is explicitly enjoined to transcend the categories which go to make up the person. As a result the relationship between the individual and the person is one of opposition, the self being realised through the negotation of this opposition.

Thus while Burridge's distinction between person and individual has a universal reference, it is brought into play in very different ways. His interest is the processes through which culture, as an abstract and enduring interpretive framework, becomes susceptible to change. He distinguishes between more traditional societies where selfhood, as the experience of society's members, arises largely out of their role as 'person' and the West where the expression or development of individuality is constitutive of the self. To stand aside from and to

creatively transgress the categories of one's own society is, in traditional societies, the institutionalised province of holders of specific roles, i.e. the shaman, the sorcerer, the sanyasin. In addition particular events or occasions such as rites of transition require the entry of specific members of a society into a position of liminality, one which is characterised by the transgressing of categories or boundaries. Thus in ritual time and space the categories through which the social world and its actors is constituted may be transformed, negated or transcended. It is within the unordered or disorderly conditions of liminality that new principles of order are discovered. Such principles may be new only to the participant; they may also, on occasion, be innovative transformations of existing frameworks.

In the West cultural innovation is the required province of every member of society. Burridge cites the meeting of Christianity and the Graeco-Roman world as the probable source of a unique generalised individuality in the West. Where the Graeco-Roman civilizations had transgressed geographical and political borders and instilled the concept of an intellectual, objective appreciation of other cultures, the Christian emphasis on love through the transcending of (others') categories took hold. It gave root to a generalised individuality - the moral requirement to stand aside from and to creatively transgress the given categories of culture.

As shown previously[3] the event of death is itself an occasion when the appropriateness of existing frameworks may be called into question, either implicitly or, at times, explicitly. In traditional societies death has often been understood as the outcome of a violation or disturbance of the moral order, for example a curse or a failure to adhere to appropriate ritual practice. As the individual dies so the duties and the sentiments proper to the person may then become susceptible to transformation or renewal. In such a context death ritual serves to contain and to structure a period of carefully demarcated

individuality.

Within the West, where a generalised individuality prevails, the event of death is the point at which one half of the required individual/person dyad is lost. In a society where selfhood is defined as a state actively oriented towards the questioning and the transformation of the existing order, for example 'thinking for oneself', 'acting on one's own behalf', the loss of the individual in death threatens to diminish or empty the self of significance.

Non-Western societies where a localised individuality prevails are therefore the broader context within which the particular history of the management of death in the West must be understood. Generalised individuality, emanating, as Burridge suggests, from the encounter between Graeco-Roman civilization and Christianity, is a fundamental and distinctive characteristic of Western history since that time. Current practices associated with death are the product of continuously changing eras, each one generated through the injunctions of a generalised individuality. It is a cultural milieu where the social order is understood as flux. Burridge describes a prevailing sense of:

> ...a present about to realise a new future - corrresponding to the way we think about what is in relation to what ought to be.
> (1979:12)

3 TRANSCENDING THE GIVEN

Along with other academic, medical or more popular authors the present work stems from more than a decade of thought addressed to the management of death 'as it is' - generated always from an implicit moral commitment to discovering the management of death 'as it ought to be'. As Burridge points out, it is within the context of a generalised individuality that social anthropology has arisen. It is one expression of a cultural requirement that

the individual should, at times, stand apart from and offer a critique of the person or the social.

Material from current popular literature and from the press gives an indication of the broad cultural milieu within which academic debate is taking place. In many cases academic debate results from generally expressed needs for precise legal, clinical or moral definitions. In each of the examples selected, the fundamental categories of experience, 'life', 'death', 'dying', 'non-life' and 'health' are publicly held up for vehement questioning or criticism. The call for an objective, intellectually constructed moral order, the inheritance of Graeco-Roman thought, is evident in this material. Also evident is the Christian legacy of an injunction to seek after truth through a love which transcends structured boundaries.

3.1 'Life' and 'Non-Life'; a blurred boundary.

There is a lack of consensus as to when a human being can begin to be described as 'alive' - for example, in the sense of having an inalienable right to survive. Prior to birth the idea that the needs of the child's mother/parents have priority is not without weight. Even after birth full membership of the category 'living' is not assumed. Hence 'reforms' in the treatment of stillborn children which carry the innovative implication that it is the dead body of a former 'living' person which is being disposed of. Should a handicapped infant survive birth its right to go on living is however not assumed. For example:

> What's wrong with Abortion ? (Scarisbrook, 1980:2) Life Publication.
>
> The question 'What's wrong with abortion ?' can be answered quickly. Fundamentally, abortion is wrong because it kills innocent human life. Abortion is death before birth. How can we be so sure ? Because human life begins at conception. That is not an opinion, a subject for debate or a matter of religious faith. It is a scientific fact.

For Ourselves. (Meulenbelt, 1981:223) Sheba Feminist Publishers: London.

The right to self-determination is still a political issue. In Britain we still have to be on our guard so that our still limited right to a safe legal abortion isn't taken away. In many countries the 'protectors of the unborn child' force women back to the back streets for abortions which often kill them, or make women suffer unwanted pregnancies and constant dread of pregnancy. The legislation of birth control today has a lot to do with population politics ... In America, for example, clinics were set up in the black ghettos to give advice on birth control, while in the rest of the country there were hardly any clinics, and there are many known cases of Indian, black and poor women being forcibly sterilised, against their will.

Mourning by the family after a stillbirth or neonatal death. (Lewis, 1979:303) Archives of Disease in Childhood.

It is the nature of stillbirth that leads us all to avoid the subject. Bourne (1968) described stillbirth as a nonevent in which there is guilt and shame with no tangible person to mourn. A stillborn is someone who did not exist, a nonperson with no name. It is an empty tragedy and a painful emptiness is difficult to talk about ... To facilitate mourning I recommend that a stillbirth be managed by making the most of what is available and can be remembered ... Bereaved parents should be encouraged to help lay out their dead baby. A post-mortem photograph, examination and x-ray will assist genetic counselling. Parents should also be persuaded to take an active part in the certification of stillbirth, to name the baby, and to make the funeral memorable. The practice of burial in a common and nameless grave should be avoided. The family should be encouraged to attend the funeral or cremation and to know of a marked place or grave.

The 69-hour life of John Pearson. (Gillie, 1981). The Times Health Supplement.

Dr Arthur wrote out instructions for the nursing staff: "Parents do not wish baby to survive. Nursing care only". He prescribed a drug, DF118, up to 5 mg every four hours to be given if necessary, to relieve distress at the nurses discretion. He told the police that he had prescribed a sedative to stop the child seeking sustenance but the significance of this phrase was strongly disputed by the defence. Dr Arthur later explained ... that the purpose of the drug was solely to reduce suffering and not to cause the death of the child.

A Suitable Case for Treatment. (Carey,1981). The Times Health Supplement.

"You are faced with the awesome responsibility of a verdict. Are you to condemn a doctor as a criminal because he cared ? Are you to condemn him as a criminal because he helped two people in their tragedy at the time of their greatest need ?" With those words to the jury in Leicester Crown Court Mr George Carman QC laid the basis for his successful defence of Dr Leonard Arthur against the charge of the attempted murder of a mongol baby. They reflect the unanimous view of doctors throughout the country and especially of paediatricians ...

3.2 'Quality of life'; medical intervention.

There is a strong commitment to the idea that being alive confers the right to go on being alive. It implies a moral imperative to actively maintain 'life' using whatever means available. For example:

Cash Shortages Limits Heart Transplants. (Gillie, 1984). The Sunday Times.

400 heart transplants a year could be performed in Britain if all available donor hearts were used. But fewer than 100 will be done this year and patients are regularly dying on the waiting list because of a shortage of money ... The demand for heart transplants is increasing steadily as doctors see the success of the operation and become more willing to refer patients - and as patients themselves become less fearful of it.

Kidney patients dying untreated. The Times, 27.9.84.

A transplant surgeon disclosed today that 1,500 kidney patients die in Britain each year because they do not receive treatment. Mr Michael Bewick, a consultant at Dulwhich Hospital, South London, said "that, statistically about 3,500 people between the ages of one and seventy suffered 'end stage' renal failure each year. Fewer than 2,000 were treated on kidney machines, placed on some other form of dialysis, or given a transplant".

3.3. 'Quality of death'; medical mismanagement.

Dilemmas are being introduced within the transition from life to death by the possibility of medical intervention. Each of these four extracts describes the bodily deterioration associated with ageing being 'treated' in terms of a medical model - i.e. as an experience to be eradicated rather than managed and made sense of. As in the fourth example, by Toynbee, death itself is put forward as a preferred alternative to that part of life which, otherwise, must be managed prior to dying. Thus within the framework of the medical model, meanings associated with the conceptual category 'life' do not extend to the deterioration of the ageing process. Should medical intervention fail to transform this process in such a way that it can be encompassed within the limitations of the category 'life' then extreme ageing is perceived to be little more than a 'living death', one perhaps more appropriately transmuted to a biological death. For example:

When medical treatment becomes an assault. The Guardian, 28.12.82, (letter).

I share Ann Corbett's sense of despair (Dec 17) over the bulldozing approach of hospital care to dying patients...(my father) was near the end of his life due to progressive heart failure, but was quite content and alert at home being looked after by my mother and the district nurse. After some random and inappropriate treatment from his GP he was eventually admitted to hospital for 'investigations'. The next few weeks were

unmitigated hell for him and deeply upsetting for my mother. The medical treatment he received was no less than an assault, reducing him in a few days to a frightened hallucinating, physical and mental wreck - he was too frail to cope with the abuse he was being subjected to. He developed infections in direct response to hospital 'care' and for the first time in his life became violent and angry with those he blamed for his suffering. My mother and I watched helplessly ...

Why dope the old into tranquillity ? The Guardian, 14.2.79, (letter).

My mother died in March after some 12 years of worsening rheumatoid arthritis, and...I got the strong impression...that nurses and doctors caring for the old commonly harm their patients by the too-free use of tranquillising drugs. Almost totally paralysed but mentally herself, my mother was asked to be admitted to the local cottage hospital for three weeks' 'experiment'...(five days later)...On entering the day-room I had to scan the line of patients more than once before recognising my mother - her condition being quite different from any any I had seen her in before; collapsed, and only able to drawl single words. The explanation for this drugging was that her groans of pain had kept other patients awake at night. At the end of her three weeks it was a question, no longer of whether life would be easier in or out of hospital, but of how many days life would go on.

The Death Kit in a Carrier Bag. The Northern Echo, 15.4.81

Death came in a carrier bag for the willing victims of Mark Lyons, 69, a court was told yesterday. Inside was a suicide kit - a quarter bottle of brandy, two plastic bags, elastic bands and tablets. The shabby man in the woolly hat, a member of EXIT, the voluntary euthanasia society...faces one count of murder and nine charges of assisting suicides... The murder charge involved Mrs Isabella Ward, a chronic back pain sufferer, who had twice tried to kill herself. Mrs Ward...joined EXIT in 1979 and was told by Reed that a man called Victor - one of a number of Lyons' alleged aliases - would call on her. When Victor arrived - he described himself as a doctor - he told Mrs Ward he would give her sleeping drugs to make her unconscious and then place a plastic

bag over her head with an elastic band round her throat.

What Arthur Koestler could do with dignity, the law forced James Haig to do brutishly and cruelly. (Toynbee, 1981) The Guardian.

Only a few weeks ago I visited a long-term geriatric ward. It was lunch time and rows of senile, incapable old women were being fed, spoonful by weary spoonful. One woman whose head lolled and tongue protruded, rocked and moaned without stopping, "No, oh no. No, oh no!" She said it all the time, every day, all day. Whatever went on in her mind, it was constant misery. The time for decisions has passed these poor old people by. How many of them would have chosen to die had they been given the choice at an earlier stage ? For the rest of us, what would we not give to save us from ending up like that ?

The examples selected reveal individuals seeking to transcend the most fundamental, 'given' categories of experience, 'life' and 'death'. At issue, for example, are the implications of medical models developed in the West since the nineteenth century, models which themselves can be seen as the product of a generalised individuality particular to European culture. They are an outcome of the questioning and eventual transcending of a former medieval world view, one through which nature had been thought of as immutable, amenable only to interpretation and not to intervention. Much of the material cited above implicitly indicts the logos (the Greek principle of an intellectual, objective awareness and questioning of cultural and social categories). It is seen to have predominated over the Christian pursuit of both truth and love through the transcending of categories and boundaries. Through rationality, generalised individuality has found its expression since Descartes. Now felt to be both inadequate as a response to a world that is, and unbalanced as a means of creating a world that ought to be, rationality as an ordering principle is repeatedly the focus of critical material of the kind presented.

To be explored is the management of death as it is, revealing the cultural and social processes through which an implicit order is created and maintained. This involves continuous confrontation with evidence of the peculiarly Western concern with the world as it ought to be. A discussion of the management of death in the West inevitably moves between present realities and an unfolding of future possibilities. To underscore the processual nature of what, from a limited view, might seem to be a simple transition from a system of implicit control, as in a residential home for elderly people, to a system of explicit care, as in the Hospice Movement, I will follow the movement or process back towards its inception at the time of early Christianity.

4 DISCONTINUITIES WITHIN THE FLOW; THE EMERGENCE OF THE CARTESIAN WORLD VIEW

A theme which helps orient discussion of this very lengthy period is the concept of health. As Illich notes:

> In every society the dominant image of death determines the prevalent concept of health. (1975:122)

Capra (1982:248-257), discussing the transition from a medieval to a Cartesian world view, highlights the now unapparent etymological connection between the words 'health' and 'whole'. Their common root, the old english 'hal', means sound, whole and healthy. 'Hale', 'heal' and 'holy' are further examples of related words whose semantic connections have now been severed. The gradual diminishing of the concept 'health' and the fragmentation of its semantic universe is one aspect of a series of pervasive transformations which have been unfolding since the rise of Christianity.

Another word which has undergone changes resulting in a depleted or reduced sphere of meaning is 'hospice'. The original sense of its root, 'hospitality', was the offer of protection, refreshment and fellowship. Records of Greek centres of healing such as Epidauris in the fifth century BC, suggest a broad concept of health which encompassed diet, exercise, the emotional catharsis of theatrical performance and the interpretation of dreams. Being oriented towards an idea of wholeness which was imaged in an idealised human body, such centres excluded dying people. Within a few centuries Roman rule saw the establishment of hospitals, institutions founded on militaristic principles for the repair of members of three valued social categories - warriors, gladiators and slaves. Lacking in the power to summon a private physician, members of these three categories received a now relatively diminished form of 'hospitality'. Only with the growth of Christianity in Rome during the fourth century AD did the concept of hospitality begin to expand again, accommodating the members of all social categories and of other countries. When Fabiola, a wealthy Roman matron, became a Christian disciple of St. Jerrome she created a refuge or hospice for all in need of protection, refreshment and fellowship. To beggars, orphans, pilgrims, sick and dying people, Christian love was extended. No social or political boundary precluded the offer of hospitality.

It was during the social transformations of the fifteenth century in Europe that the concept 'health' came to acquire a much more specific and also more limited sphere of meaning associated with control and cure. Nonetheless in 1902 when a small group of Irish Sisters of Mercy sought to accommodate the range of human suffering which fell outside this limited sphere, the word hospice was reintroduced - and St Joseph's Hospice for impoverished dying people was opened in the east end of London. So successfully has the concept 'hospice' evoked forms of care which transcend the limited medical model of health that by 1980 fifty-five hospices had been established in Great Britain.[4]

With the changing concepts of 'health' and 'hospitality' as reference points I will return to Capra's assertion that the scientific revolution of the sixteenth century was a major turning point in the way which the world was understood in Europe. Prior to this period the hospice established by Fabiola became the model for monastery-based hospices which functioned as way stations for pilgrims. Throughout this medieval period the legacy of Aristotle's comprehensive view of nature, combined with the Christian view of the immanence of God in all things, had given rise to what Capra describes as an organic world view. Thomas Aquinas, during the thirteenth century, brought together reason and faith in a cultural framework which asserted the inter-connectedness of every aspect of both spiritual and worldly domains. During the two centuries leading up to 1500 the role of the human being was seen to be of an interpretive rather than predictive or controlling nature. Thus everyday experience was made sense of through a metaphoric framework which encompassed spiritual and earthly domains within a single model.

Copernicus' discoveries in astronomy represented not only a profound challenge to geocentric assumptions about the physical nature of the universe but also a threat to the experiential reference of religious metaphors. Through the work of Kepler and Galileo, Copernicus' hypothesis became established as valid scientific theory. Galileo went on to develop a philosophy which enjoined an empirical approach to knowledge and the use of mathematical language in descriptions of nature. Such an approach became feasible only through the reduction of 'nature' to its quantifiable attributes - shape, number and motion. The empirical approach to knowledge was taken up and vigorously developed by Francis Bacon. Capra cites the 'Baconian Spirit' as critical in the pursuit of knowledge for the purposes of control and domination rather than understanding and integration.

In keeping with the pentecostal experience of immediate conversion which lies at the heart of a generalised individuality in the West, the more extensive system of thought developed by Descartes in the seventeenth century stemmed from an illuminating vision which he experienced at the age of twenty-three. Interpreting the experience as divine inspiration Descartes envisaged and promoted a complete science of nature. It was grounded in a newfound belief in the possibility of absolute mathematical certainty in scientific knowledge. Being above all analytic in nature, Descartes' method stands squarely in opposition to a medieval world view which stressed the integrated quality of the universe. Thus the world view which dominated Western thinking and shaped Western experience during the three suceeding centuries was rooted in the assumed authenticity of the machine as a metaphor for the material world. Graspable only through the disciplined intellect which rejects that knowledge which has not been reached by deduction, the material world came to be experienced through scientific frameworks which reduced its depth and complexity to fragmented, constituent parts.

Infused with the Baconian spirit and effective in allowing testable mathematical laws of nature to be formulated, such metaphors lent momentum to the notion that the material world was now amenable to human control and domination. Whilst the integrated nature of the medieval world view involved the immanence of God in every part of the universe, the analytic models of the suceeding era assumed God as the (separate) creator or source of an unchanging, rigidly ordered natural world.

Newton's further development of Cartesian models during the seventeenth century ensured the extension of the machine metaphor of the natural world into the areas of human nature and human society. Rationality as the cornerstone of a broad range of intellectual endeavours found its full expression in the work of Locke. The generalised individuality which implicitly prompted

evermore refined versions of a rational world view, materialised in Locke's theories of individualism. In a universe experienced as an assemblage of separate elements or building blocks, the single human being came to be seen not as the innovative meeting point of the person and the individual, but rather as a separate inviolable being possessing rights which were independent of larger communal concerns.

It is within the broad context of intellectual developments from the sixteenth century onwards, when contrasted with the previous medieval world view, that changes in the concepts of 'health', 'life' and 'death' become more coherent. The effectiveness of current medical practice is one aspect of a world view which must be seen as a unique deviation from the modes of thought which prevailed and, still, persist in other societies. The model of the human body as a machine which exists independently of both the mind and of other human beings has facilitated not only knowledge of its workings but also powerful curative techniques. Nonetheless the effectiveness of medical models in illuminating certain aspects of the human organism has arisen to the exclusion of the broader range of dimensions encompassed by the more traditional concept 'healing'. Thus the cause and effect, deterministic mode of thought which had arisen by the time of Newton was readily transposed to the human body. Taxonomies of disease were constructed according to the principles embodied in Linnaean classification of living forms. Once identified in this way diseases came to be thought of as the isolable causes or sources of ill-health. With effective diagnosis they could, ultimately, be traced back to the malfunctioning of a single organ within the body.

In summary, Capra argues that medical models are, predictably, successful in the cure of an individual's disease. However, when viewed more broadly, they cannot be shown to have had any major impact upon the overall health and well-being of populations. What Capra demonstrates is the singularly innovative and

influential nature of Descartes' thought and work. He also shows that many of the economic, political and social problems currently facing the world as a whole can be understood in terms of the very powerful and far-reaching scope of the mode of thought embodied in Descartes' work. The mastery of the natural world and the resulting advances in fields such as technology, communications and curative medicine are all the product of a reductionist science which has isolated, fragmented and simplified many aspects of the natural world ranging from the planetary system to the human body. In so doing the interdependent, integrated nature of such a world has been downplayed thereby precipitating a whole series of problems which at source must be seen as ecological.

Capra also examines some of the responses to these problems which have arisen during the last twenty years. From the margins of established centres of power the Women's Movement, the Green Party, and the development of holistic medicine have arisen. Stemming from a period of economic affluence in the West their shared concerns are, implicitly, the limitations of paradigms which reflect a Cartesian world view. Not only is there a commitment to questioning the external boundaries of current metaphors or models, such as those reflected in the marginalising of the social categories 'women' or 'the terminally ill', there is also a concern to stress currently unapparent sets of interdependencies, such as the relationship between world rainfall and world forestation or the relationship between environmental stresses and ill health in human populations.

Each one of these groups shares an underlying orientation with the apparently very different and politically far more powerful group, the 'moral majority' in America. Though this group upholds rather than questions well-defined traditional models concerning, for example, sexual mores, the 'moral majority' is nonetheless a Fundamentalist Christian Movement which firmly espouses a religious rather than a purely materialistic world

view.

Alongside such movements which have arisen in the West can be placed the revolutionary or revivalist activities which are emerging continuously in non-Western societies. In many cases they represent a conscious choice to resist or reject the imposition or encroachment of a Western reductionist world view which disinvests the material world of its moral and spiritual significance. A powerful example of such a choice can be seen in the rapid and popular development of Muslim Fundamentalism in the Islamic world, of which Iran is but the most extreme example.

Ultimately Capra underestimates the effectiveness of the Cartesian world view. Its orientation towards the right of the individual to assert their own interests in a single-minded fashion is currently coupled in a very powerful fashion with the effective means of accumulating wealth through technological control of the material world. Whilst the limitations of such an approach are becoming increasingly apparent, particularly to those whose resulting quality of life is often severely diminished, the successful development of alternative metaphoric frameworks is itself dependent upon Western economic affluence.

For example, it is economic security which has made possible an extended period of education for young people, an increased financial and reproductive independence for women, and an essential availability of funding for ventures such as hospices. In each of these areas constraints are now being felt as a result of the current recession in the West. As the destructive imbalances of the Cartesian world view continue to take effect the development of innovative alternatives becomes increasingly vulnerable. Ever fiercer attempts are being made by those who have benefitted most from an exploitative approach to the environment, to maintain rather than relinquish their assets of wealth and power.

It is during this latter period, and in the specific areas of ageing, dying and bereavement, that work for this thesis has been in progress. Its principle foci are certain of the areas of human experience which have become increasingly peripheral to the mainstream of a controlling rather than an interpretive culture. Ageing is a particularly relevant category of experience. The increasingly top-heavy population structure of Western societies can be seen as both the successful outcome of an improved material standard of living and also an intractable drain on a medical system grounded in cure-oriented specialisms.

Hospice and bereavement support organisations have arisen very much in response to forms of social, emotional and physical suffering which, like the ageing process, are not accommodated within the dominant Western world view of the last three centuries. These movements manifest the same generalised individuality which saw the emergence of Cartesian thought out of the organic world view of the Middle Ages. As already suggested, the transition from one mode of thought to another can be seen as a continuing process which, as Burridge argues, has its inception at the meeting point of early Christianity and the Graeco-Roman civilizations. In this respect it is a process which must be seen as a special case, a unique departure from more traditional societies in which individuality has been contained and constrained within specific institutionalised times, spaces and roles.

Capra's work explores changes occuring within many areas of life from the Middle Ages onwards. These include physics, health, economics and the global environment. Demonstrating their interconnectedness he argues singlemindedly that the emergence of an analytic mode of thought has involved the creation of boundaries within and between many hitherto coherently-linked realms of human experience. Capra entitles his work 'The Turning Point', a phrase which effectively describes the 'field' within

which this thesis has been produced. Through the opposing processes of both fragmentation and flow, death is currently being managed in Great Britain today. Thus the movements which seek to re-create an experience of continuity between life and death must operate within a broad social context where bodily processes inconsistent with the socially constructed state of 'adulthood' are made consistently marginal or peripheral. Both the maintenance of and the de-construction or reconstruction of boundaries go on simultaneously at this turning point in the Western management of death.

NOTES

1. 'Science as a Vocation'. Public Lecture, 1919.

2. Cicely Saunders, quoted in:
   'St Joseph's Hospice', Nursing Mirror, 21.8.1980, p.20.

3. See Chapter One, pages 11-12.

4. See Richard Hillier, E. (1983:323), Table 24.1, Development of Hospice services in Great Britain.

CHAPTER FOUR

'LIFE' AND 'DEATH': THE MEDICAL FRAMING OF CONCEPTUAL CATEGORIES

Discussion of the transition from a wholly religious to a largely scientific Western world view raises the earlier theme - of 'life' and 'death' as culturally specific categories, and their relationship to one another.[1] The scientific or medical frameworks through which these categories have come to be thought about and experienced can now be explored in more detail. As shown, each society encounters death through elaborately conceived and 'authentic' metaphoric frameworks. Cross cultural comparison reveals that aspects of death are variously highlighted or downplayed in different societies. The boundary between the biological states of being alive and being dead is nonetheless given universal cultural and social elaboration in some form or another. It is out of the shape of this temporal and spatial boundary that the categories 'life' and 'death' each assume their culturally specific nature. In the three ethnographic examples quoted 'life', 'death' and their separating/ mediating boundary were understood in terms of ethnicity, outsiderhood, dance and marriage patterns, and socially deviant behaviour. Examples such as the Hindu ascetic and the Hindu householder[2] show just how broad and variable the meanings encompassed by these categories can be.

Earlier discussion of the management of death was addressed to the question of how a particular model comes to provide an 'authentic' experience of reality.[3] The transformation of a society where religious frameworks had once provided this kind of experience has also been traced.[4] At present the later, medical models which became widely accepted during the first half of the twentieth century are themselves being questioned, for example through the practices of the Hospice and Bereavement Support Organisations. Nonetheless it is through the practices of

established, professional social classes associated with medicine, that a divisive boundary between 'life' and 'death' continues to be maintained, for example in the spatial separa of living, in the domestic sphere 'home', and dying, in the medical sphere 'hospital'. In 1984, as Table 1 shows, only a 25% of all deaths occured in the person's own home: Nearly 70 took place in institutions.

Table 1. Place of Death in England and Wales, 1984.[5]

	M	F
Total number of deaths	282,357	284,524
Place of death		
NHS psychiatric hospitals	4,590	6,236
Other " "	96	2,250
NHS hospitals & institutions for the sick	158,981	160,564
Other " "	8,790	15,132
Other institutions	8,285	23,391
At home	81,748	66,695
Other homes/places	19,867	12,281
Summary		
Death in institution	180,742	205,548
Death at home	81,748	66,695
Other homes/places	19,867	12,281

In this chapter I will examine the medical model as one set c 'structured metaphors' through which death is still encounter in Great Britain today. Drawing upon Illich's work on the medicalization of society (1975), I will explore the signific of this metaphoric system and show the aspects of death which highlighted through its operation. As suggested previously,[3] 'truth' or 'authenticity' of such a system is contextual and essentially incomplete. Whilst its creation and re-creation in the form of postulates, it is a partial and selective acc

or interpretation of experience. Herein lies its susceptibility to change.

In the course of the last twenty-five years the medical model has repeatedly been questioned, modified, extended or indeed set to one side. For example, in 1967 the Hospice Movement emerged in its present form. In 1959 and 1969 two major organisations offering support to bereaved people came into being. All three are expressions of rather different models of death. What I will show in this chapter is how 'new' metaphoric systems such as those expressed in Hospice and bereavement organisations arise out of and are addressed to aspects of death which are excluded from a previous system. In the limitations of one model may be discovered the core of a successor.

Given that traditional medical models are either preventive or curative, neither therefore address themselves directly to managing the implacable and incurable processes of dying and bereavement. In the Hospice and the bereavement support organisations, that which was marginal to a traditional medical model has been appropriated as a central area for thought and practice. I have chosen these two examples not only because they demonstrate an innovative mode of encountering death but also because their approach has extensive implications for a far broader range of 'health' issues. These include the control of pain in chronic as well as terminal illness; the maintenance of social identity in all individuals for whom an improvement in mental or physical health is unlikely, for example chronically ill, mentally and physically handicapped and very elderly people; the negotiation of honesty and a symetrical relationship of power between doctors and all patients. Like the management of death, these are 'health' issues which have ethical and moral, political and economic dimensions.

1 'LIFE', 'DEATH' AND 'HEALTH'; THE MEDICAL MODEL

Cross cultural comparison reveals a broad and disparate range of meanings embodied within the cultural categories 'life' and 'death'. Since Hertz's work on handedness (orig.1907; 1960) the notion that biological states may be variously interpreted has long been accepted within social anthropology. When scope is restricted to one culture or country, such as Great Britain, it becomes apparent that fluidity or ambiguity in the interpretation of biological states is an emotive and indeed politically explosive area of life. It is a question of contextual rather than universal truth. Through consistency and coherence the experienced authenticity of a particular cultural system becomes established.

In Great Britain and the West today technology associated with health allows for very thorough and precise descriptions or distinctions to be made with respect to bodily states. The possibility of unwavering and infallible medical interpretations has become absorbed into the way in which the body, in life and in death, is conceived of.

This is exemplified in difficulties experienced by bereaved people encountered in the course of fieldwork. Should the medical management of their relatives' death fail to conform to a very well-defined set of expectations, strong anger could be felt - for example, if a terminal illness was not diagnosed or if they were not forewarned accurately about the time of death. Similarly, death is commonly understood in terms of a medical cause-and-effect relationship. It is the previous medical history which is often scrutinised by surviving relatives when they seek to make sense of what has happened. For example, in a large proportion of all deaths (approximately 50%) a cardio-vascular disease is given as the cause.[6] If the deceased engaged in none of the specific behaviours such as worrying, smoking or

drinking which are commonly thought to be pre-disposing, then difficulty may be experienced by relatives in accepting the death.

If however a survivor experiences no dissonance between a medical model and their relatives's death, the death may then be described primarily in terms of the medical definitions put forward by a practitioner at that time. For example a widow's first, brief description of her husband's sudden death included a relatively extensive report of the dialogue which took place between herself and the doctor on the day of his death.

> **"Is it serious ?"**
> **"I'm afraid it is. He seems to have had a heart attack."**
> **"Will he get better ?"**
> **"I'm afraid he won't. I've taken his blood pressure and he has almost none".**

As her husband dies she experiences the event through the medically authentic definitions which she seeks from the doctor. His are the words which she repeats when she re-describes what happened.

It is within this climate of opinion or cultural milieu, where the precise discriminations and distinctions of the medical model hold sway, that debates are now taking place about the boundary between the cultural categories 'life' and 'death'. Religious, moral, ethical and medical frameworks fail to cohere in a single, consistent and authoritative body of thought. Thus, for example, clear definitions are felt to be lacking concerning the status of the foetus; of stillborn and congenitally handicapped children; of adults surviving only with the major medical support of organ transplant or kidney dialysis; and also of frail elderly people.[7] In each case the same question underlies the debate. What is it that is being described when the words 'life' or 'alive' are used? What is their current meaning in Great Britain today ? While the deaths of neither the Hindu ascetic nor the householder

coincide with simple bodily changes such as cessation of heart-beat or breathing,[2] reflection on the social identity of the foetus, the stillborn or handicapped infant, and the chronically ill adult or elderly person in Great Britain today reveals that here too there is no simple correspondance between bodily state and cultural and social category.

With technological measurement and control of the body becoming increasingly refined, the development of the foetus is now routinely observed, premature and severely handicappped infants are reared and the adult body can be made to accept organ transplant or to survive without major organs. Indeed it can be made to continue its existence with only minimal brain function. Technological control and material provision therefore ensure bodily survival for a far broader spectrum of human beings, from the extraordinarily premature to the greatly aged, from the bodily mutilated to the profoundly mentally handicapped.

Alongside such technological changes, overall material well-being has increased in the form of improved sanitation, housing, shorter and less arduous hours of employment. The expectation of good health has been established and indeed the availibility of medical remedies for illness or handicap often makes for the removal or invisibility of disfigurement, mutilation or loss of bodily control. Thus in a material sense the possibility of an improved quality of life has been made available. In addition life expectancy, or quantity of life, has increased at the same time.

It is the co-incidence of an overall increase in the quantity of life and an improvement in the material quality of life which raises questions about where the boundary between life and death lies. There is tension between the new-found possibility of survival for even the frailest human beings and the newly acquired expectation that living should be a materially comfortable experience. Given that medical technology allows

unprecedented control of the boundary between life and death these questions are not merely abstract or theoretical. They are practical questions which have powerful emotional, economic and political implications. Material from popular literature and from the press[7] illustrated some of the issues which have arisen and some of the areas of greatest ambiguity if not conflict. These include abortion, stillbirth, congenital handicap, organ transplant, medical care/cure of elderly people, euthanasia.

In each of these areas the possibility of making a medical intervention into a bodily condition raises questions. Whether such interventions have the effect of maintaining bodily function or of causing it to cease, the responses of different social groups or categories can vary in the extreme. For example, those espousing a moral or religious point of view may perceive them through metaphoric frameworks which bear little correspondance to the metaphors brought into play through an economic or political perspective.

In 1981 Dr Michael Thomas, chairman of the British Medical Association's ethical committee, is reported[8] as saying that:

> ...he regretted that the 'fantastic explosion' of medical scientific advances over the last 20 years had not been accompanied by the sort of public debate that had led to the establishment of bodies like the General Medical Council in the last century. "I am worried about the fact that we are having a number of ethical debates which come and go without reaching any adequate conclusion. The mechanism of 140 years ago whereby the public's view became embodied in an ethical code seems to have atrophied".

In summary a need is being expressed for widely acceptable and more refined definitions of and distinctions between what is meant by the cultural categories 'life' and 'death'. Whilst medical/technological skills become more precise and more powerful, their application does not fall easily within the

previously well-defined doctrines of the church. Indeed these doctrines themselves are undergoing a process of change and are being interpreted more fluidly - for example, the church's teachings on pre-marital sex, homosexuality, divorce and the ordination of women.

This combination of circumstances produces a whole range of paradoxes or dilemmas. They include the following examples:

(1) The search for clarity can produce an inflexible mode of thought within which the specific circumstances of the individual cannot be accommodated, for example the introduction of a rigid legal framework within the medical management of life and death.

(2) The Christian moral imperative to 'love thy neighbour' can create insupportable pressures when 'thy neighbour's' existence is viable only through the extra-ordinary power of medicine to keep death at bay.

(3) Through medical technology the principle of rationality can be implemented with a rigour which excludes other aspects of human experience such as intuition, flexibility, individuality.

In material drawn from the popular press, a key arena for public debate, these paradoxes are addressed.

The death of twenty-two day old Michael Hicknott, a brain-damaged baby born prematurely after his mother's death, drew public attention to the lack of consensus in the management of death. Bel Mooney, writing in the Sunday Times, argued that both rigid medical practice and also immutable ethical doctrines were inhumane:

> Had he lived, Michael Hicknott would have been brain-damaged - but there are countless parents who would testify to the great joy that can be brought by such a 'bleak' life. On the other hand, there are also parents who

> are driven mad by the exhaustion of looking after such a child, and for whom love dwindles grimly into a question of duty. Those truths run parallel ... Admittedly such agonised confusion places almost intolerable weight upon the shoulders of doctors and parents. But clarity would reduce human emotion to the level of the catechism. Naturally it would please the favoured who know God, and therefore right and wrong. It would worry the rest of us, who suspect that God only exists within the potential of each human being (a doctor, a parent, a friend) to behave rightly, with pain, dignity and love. (1983:38)

Bel Mooney writes from the premise that 'we', her readers, are not committed Christians. She asserts that the power of medical technology, through which even severely physically damaged infants can be made to survive, must be used 'pragmatically' - that is to say fluidly, with respect to the individual. What is called for is a mode of thought within which medical practice is informed by clear yet humane ethical doctrines. For the uncertainties over the boundary between life and death, arising out of its control through medical frameworks, there is felt to be no resolution which is both definitive and also humane. The rational principles through which the science of medicine is constituted often prove unwieldy in the management of individual experience. At the boundary between an individual's life and death the precise techniques of medicine can appear as a rigid system without the flexibility necessary to accommodate all aspects of individual experience at the end of life.

For example, editorial comment in the Times Health Supplement at the time of the trial of members of the pro-euthanasia group, EXIT, drew attention to the inappropriateness of a purely rational response to individuals encountering the end of their lives.[9]

> People often say they don't want to go on living. They do not want or expect a man to rush round with drugs and a plastic bag. More often it is a cry for company, reassurance, support or a symptom of depression...Reed's overzealous response, though rational, made no allowance for the irrationality of human nature.

Nonetheless within a society where a rational, analytic world view, however problematic, continues to be espoused, an intuitive or interpretive approach is not easily embraced. In 1982, Dr Garrow, a paediatrician at Whickan Hospital, spoke before a predominantly medical audience of his intuitive approach to the management of new-born handicapped infants. He had become the focus of controversy in that he had let it be known publicly that at times he allowed such babies to die. Dr Garrow alluded to the uneasy relationship between rational and intuitive approaches to medicine, saying that the clear difference between the idea of killing and the idea of not preserving life was "ticklish in practise". He spoke out against "abstractions", "principles" and "rights", describing how he allowed a baby to "decide its own fate" in that he followed his own intuitive responses to any "appealing gestures" it might make. In a society where the rational, medical mode of thought predominates, Dr Garrow's public avowal of a flexible and empathic approach to the meanings encompassed within the categories 'life' and 'death' drew a powerful, negative emotional response. Nursing staff in Dr Garrow's audience clearly found the implementation of such an apparently 'arbitrary' approach very distressing.

Examples such as these reveal a persistent tension between a felt need for rigid definitions and strict procedures and the desire for flexibility sufficient to accommodate the needs of the individual.

Nonetheless otherwise unaccountable emotional as well as bodily experience does still continue to be controlled and given form through a medical mode of thought which is seen to embody the ideas of rationality and predictability. Comments published in the Guardian by K.Nichols, a clinical psychologist, draw attention to a collective myth of the infallibility of medicine.[10] He notes:

> The myth takes the form of an idealisation of the medical services, a feeling that the doctors are totally reliable in the task of diagnosing disease, repairing failing body parts and staving off death. The everyday realities of medicine, the slip-ups, errors, doubts and confusions must be denied in order to minimise anxiety. This need is in us rather than the doctors, but in its development the medical profession has elected to collude with this defence.

In the next section of this chapter I will focus on the 'myth of medical infallibility' and explore some of its implications. As the psychologist notes, it is a myth which is embraced by both medical practitioners and 'patients'. As the examples presented in this chapter and in the last have shown, discrepancies between private experiences and their medical interpretation, between ethical enigmas and technological competence, all give rise to confusion and concern. This material illustrates Geertz's discussion of the critical role of cognitive coherence in human experience. Along with suffering he cites 'bafflement' and 'a sense of intractable ethical paradox' as:

> ...radical challenges to the proposition that life is comprehensible and that we can, by taking thought, orient ourselves effectively within it - (1968a:14)

Given that such paradoxes are introduced within the cultural framing of life and death through a medical model, both the practice of medicine and the practice of using medical advice/ techniques are pursued in terms of the myth of medical

infallibility. It is in this way that the associated 'sense of intractable ethical paradox' or 'bafflement' is managed.

2 CANCER AND THE MYTH OF MEDICAL INFALLIBILITY

Illich's work on the medicalization of society (1975) and Sontag's discussion of illness as metaphor (1983) together shed light on the personal and political implications of the myth of medical infallibility and the ways in which its limitations are currently becoming apparent. As shown, strenuous attempts are being made to create a public reconciliation between medical and ethical modes of thought. Other attempts are being made to modify or expand upon a traditional medical framework. Illich traces the history of today's tenacious myth of medical infallibility. Sontag focusses specifically on illnesses such as TB and cancer which have eluded satisfactory medical explanations/treatments and have therefore remained open to a proliferation of alternative metaphoric interpretations. As will be shown, deaths from cancer currently represent a challenge not only to the skills but also the conceptual frameworks implicit within medicine. Furthermore it is significant that cancer predominates among illnesses to which alternative approaches to medicine have been addressed. These include the Hospice Movement and the Bristol Cancer Help Centre.[11] As Nichols,[10] the clinical psychologist goes on to note in his article:

> (of the hospice) The critical difference here is that dying people have been told honestly of their position and the doctors are no longer pressured to be sources of infallible diagnosis and treatment. They are allowed to be honest. A real rapport can exist between the doctor, nurse and dying person.

In Illich's work on the medicalization of society, death and its management is given particular weight (1975:122-150). He examines the contemporary Western concept of 'natural death'. Ethnographic material from non-Western societies is a reminder

that death has often been thought of as an 'unnatural' occurence, an event explainable only as the outcome of deviant or malignant behaviour on the part of either the deceased or other members of their society.[12] Illich traces historical developments in Western concepts of death during the last 500 years.

Changing religious iconography depicts the transition from the fourteenth century image of death as the indwelling, immanent condition of life, where living figures entwined with their dead counterparts in the Dance of the Dead, to the fifteenth century image of death as a controlling, natural force visited upon human beings in a once-in-a-lifetime encounter - and death was personified in the Danse Macabre. During the Middle Ages life on earth had been seen as a sacrament of God's presence and the biological event of dying was perceived merely as a transition from a state of earthly to heavenly grace, a passage from the Church militant to the Church triumphant. Under the fifteenth century influence of the Reformation and of Lutheran thought, earthly life came to be perceived as corrupt, and redemption was only made possible through faith in God. Thus the figure of the grim skeletal Reaper, embodies the idea of death as the final, definitive boundary of a corrupt earthly life. Heavenly grace or hellish punishment lay as twin possibilities on the other side of that boundary, neither of them embodying the certainty commanded by death itself.

It was this death which was anticipated by those living in the late fifteenth and the sixteenth centuries. The linear clock-time of their earthly life was bounded by an event which was encountered by the dying individual rather than the living community. A man or woman took personal responsibility for the manner of their own death, viewing it as an occasion to which they hoped to be able to rise.

Thus 'natural death', conceived as the indwelling condition of life, came to assume the characteristics of an inevitable and important once-in-a-lifetime personal encounter. Illich cites this period as significant in the initial medicalizing of death. The moment of death, to be properly managed, must be properly anticipated. Through medical folk practises, distinctions between transitory and mortal illness could be made. If a mortal illness was diagnosed the application of remedies to ease and speed the transition could be carried out under the direction of the dying person. Hoping thus to be spared overwhelming agonies, the individual sought to make a dignified exit.

Illich goes on to show the subsequent transformations of this approach and pursue their political implications. The predominant image of Death as Leveller or Grim Reaper is evoked through the words of sixteenth century liturgy,[13] pronounced whenever a corpse was lowered into the earth:

> Man that is born of a woman hath but a short time to live, and is full of misery. He cometh up, and is cut down, like a flower; he fleeth as it were a shadow, and never continueth in one stay.
>
> In the midst of life we are in death .....

In the rigidly hierarchized society of that time the iconographic depiction of king, bishop, doctor, merchant each encountering their final deathly visitor suggests the ephemeral nature of worldly status. As Illich notes:

> Precisely because macabre equality belittled worldly privilege it also made it more legitimate. (1975:134-5)

Why seek to overthrow that which is shallow and transitory ?

With rise of a new, wealthy middle-class in the eighteenth century, the anticipatory comfort of equality in death gave way to the concept of 'natural death' as that which money could ensure, or reserve, for certain social classes. Medical remedies, once an aid in the transition from life to death, now assumed the new role of a valuable commodity, disparately accessible to rich and poor. Similarly, medical skills and knowledge were firmly appropriated as the exclusive property of the doctor. By the nineteenth century the unprecedented power to step between the individual and their death was attributed to members of the medical profession.

In the twentieth century the idea of equality in 'natural' death assumes new political implications. With dying perceived as the predation of multiple killer diseases, 'health', and indeed 'life', come to be seen as that which medical technology underpins. As shown previously, distinctions between 'life' and 'death' are matters arising out of, and discussed in terms of, a medical mode of thought.[7]

From another culture Bourdieu offers a parallel example - of a Kabyle woman making a conscious distinction between a former social role, 'dying', and a current, medically defined condition, 'dying'.

> In the old days, folk didn't know what illness was. They went to bed and they died. It's only nowadays that we're learning words like liver, lung .. intestines, stomach .. and I don't know what! People only used to know (pain in) the belly .. that's what everyone who died died of, unless it was fever ... (1977:166)

As a set of metaphors the hegemony of a medical model is such that major inequalities in the distribution of wealth and in the quality of living and working environments can be subsumed, and thereby masked, within claims for equal access to medical care and therefore to a 'natural death'.

In summary Illich, by exloring the concept of 'natural death' as one particular, developing metaphoric interpretation of death, shows its key role within the hegemony of a medical model. Through this imaging of death two myths are promoted - one is the myth of medical infallibility; the other is the myth of a deterministic, unilinear relationship between equal access to medical services and 'social progress'. Illich asserts that:

> The myth of progress of all people towards the same kind of death diminishes the feeling of guilt on the part of the 'haves' by transforming the ugly deaths of which 'have nots' die into the result of present underdevelopment, which ought to be remedied by further expansion of medical institutions. (1975:146)

Illich's work gives very useful insights into the ways in which current medical frameworks have evolved. His appraisal brings out the political implications which secure the continuity of such an approach.

In a very different fashion Berger's portrait of an isolated country doctor, John Sassal, shows how the practice of medicine can expose the practitioner to the limitations of his model (1976). Sassall, the Fortunate Man of the book's title, finds himself in the privileged position of 'gentleman' within a small economically depressed rural community. More than any sense of medical inadequacy in the face of incurable illness, Sassall is dogged with an awareness of the more pernicious inadequacy of medicine as a remedy for cultural and economic deprivation. Berger writes:

> I do not want to exaggerate Sassall's dilemma. It is one that many doctors and psycho-therapists have to face: how far should one help a patient to accept conditions which are at least as unjust and wrong as the patient is sick ? What makes it more acute for Sassall is his isolation, his closeness to his

> patients and a bitter paradox which we have not yet defined.
>
> I believe that Sassall's disquiet is provoked...by the contrast between the general expectations of his patients and his own. (1976:141)

Berger's exploration of the experience of a single medical 'insider' lends support to Illich's argument which stems from a more generalised, historical perspective. Together their work indicates important dimensions of the historical background and current cultural and social context of contemporary initiatives such as the Hospice Movement. Whilst a medical framing of 'life', 'death' and 'health' produces apparently insoluble paradoxes, the myth of medical infallibility which has slowly become entrenched over time remains as the prevailing orientation towards the practice and use of medicine.

Illich's argument that medical frameworks carry powerful political implications is borne out in the fact that differences within mortality statistics related to social class were already being made evident in the early part of this century by Dr T.H.C. Stevenson, superintendent of statistics at the General Register Office (1928). Townsend notes that:

> ...his special interest was the influence of wealth and culture on mortality and morbidity. (1979:369)

Whilst awareness of this 'influence' has therefore been long established, the 1980 Black Report on the persistence of class-based inequalities in life-expectancy despite the introduction of the Welfare State, was semi-suppressed. Patrick Jenkins released just 260 xerox copies of the original report and it was only in 1982 that Townsend and Davidson made it widely available in a shortened form (1982).

Though the relationship between social class and health has to some extent been acknowledged within the medical profession its political implications remain submerged within the more dominant emphasis on changes in dietary and exercise habits to be made by the individual. Death, as framed within the mortality statistics, nonetheless remains as a powerful challenge to such an approach. Those geographical areas identified within the Black Report as having a particularly high early mortality rate are currently the focus of research into the environmental/ cultural conditions of social groups and categories where death comes earlier.[14] Using anthropological and oral history techniques this research sets out to reconstruct what might otherwise remain as the purely 'medical' histories of such populations.

In turning directly to the Hospice Movement and those individuals who represent the majority of its patients, it becomes apparent that deaths from cancer have played their own role in the recent modification and expansion of a medical mode of thought. I will look closely at the nature of this illness in order to explore in more detail the cultural and social processes through which the Hospice Movement has come into being.

Cancer is an unpredictable, invasive illness which has not as yet been satisfactorily encompassed within current medical frameworks. In 1982 it was the stated cause of almost a quarter of all non-violent deaths.[6] Illich has stressed medicine's central defensive/aggressive role at the boundary between life and death. And indeed public debate and the attitudes of bereaved people demonstrate considerable widespread emotional investment in this state of affairs. As Illich suggests, the myth of medical infallibility defines 'bad death' as that which takes place without past or present medical treatment. It is disordered, unpredictable, uncontrolled. Nonetheless almost a quarter of us must expect to end our lives with a protracted

period of uncomfortable or painful illness for which, it is commonly thought, there are no adequate medical remedies.

Cancer, with its invasive yet elusive qualities, can be seen as a 'bad death' of another kind. It is the death which reveals the inauthenticity of the myth of 'natural death' as that which is experienced by the consumer of medical services. Lying outside simple, conventional medical frameworks or interpretations (being thought of as incurable, inexplicable), cancer attracts a proliferation of alternative metaphoric associations.

Sontag writes from the following proposition.

> The fantasies inspired by TB in the last century, by cancer now, are responses to a disease thought to be intractable and capricious - that is, a disease not understood - in an era in which medicine's central premise is that all diseases can be cured. (1983:9)

The 'fantasies' which she explores provide further examples of ways in which the body can be used as an experiential grounding for the metaphors through which more pervasive and less tangible dimensions of worldly experience are conceptualised.[15] As Sontag suggests, an illness thought of as incurable and therefore fatal attracts a fluid range of metaphors which expand into areas of life lying beyond the more limited scope of medical frameworks.

An additional example is AIDS, an incurable disease acquired, like TB, through contagion and experienced, like cancer, as a stealthy, invasive killer. Lying beyond the curative frameworks of a medical model, its associations with 'uncontrolled' and 'unnatural' sexual mores have been elaborated extensively.

Like Illich, Sontag argues effectively by including a historical perspective in her thought. Perceptions of TB in the nineteenth century provide a further example of the possibilities for metaphoric elaboration offered by an illness without a simple,

medically identifiable cause or cure. Only with Koch's discovery of the tubercle bacillus in 1882 did the disease's associations with romanticized poverty and aesthetic enfeeblement give way to the more prosaic processes of innoculation and sanitary inspection.

Sontag brings together ideas about the causes of cancer, and about its nature, going on to show how these ideas are used metaphorically to think about areas of life such as politics and morals. She demonstrates the circularity of metaphoric reference which Bourdieu describes in the terms already cited:

> ...the mind is a metaphor of the world of objects which is itself but an endless circle of mutually reflecting metaphors. (1977:91)

Lacking a simple biological cause, and indeed failing to manifest itself in a single, isolable form, the causes of cancer are variously interpreted, whilst its source is variously located. As Sontag shows, the nature of the self, that is to say the personality, is often seen as a major predisposing factor in cancer sufferers. Thus a self-pitying, emotionally repressed individual is thought to be particularly prone to the illness. Similarly a personal failure which produces a sense of hopelessness or resignation is thought of as a predisposing circumstance. Sontag argues that there is a sense of implicit blame attached to the occurence of cancer - and that that blame is subtly attached to the ill person themselves. As a result a disease thought to stem from a repressed emotional style and a sense of personal hopelessness comes to attract stigma of a particularly humiliating kind. In an almost punitive sense the malignancy which arises from within individuals perceived to be somehow lacking is then seen to take over that individual in a parasitic fashion. It diminishes them further as mutant, alien cells replace 'you' with 'non you'.

Again responses to AIDS sufferers can be seen as a parallel example. Assumed to be members of a separate and disordered social category, their sickness is not only seen to reveal their deviance but also acts as a stigmatising barrier which marginalises and distances both their social category and their disease.

In tandem with the shaming of the individual in this manner another body of thought attributes cancer to the perceived ills of the environment. Blame attaches to a whole range of factors from food additives through to airborne radiation. Whether from within or without, cancer is thus seen to result from the perceived ills of our time. Indeed Sontag traces a changing perception of conducive conditions or personality traits. The Victorians thought of grief and rage, poverty and overwork as its causes. This contrasts with the emotional isolation and material excess currently identified as predisposing conditions. In the absence of simple medical explanations cancer is seen to embody the broad dimensions of experience defined as deviant or troubling. Processes of this kind - i.e. an 'unnatural', overcontrolled emotionality giving rise to growing inner corruption - are then used metaphorically to identify other non-bodily processes such as moral corruption.

One critical question arises at this point - whose are the prevailing definitions through which cancer is understood ? Guilt over diets rich in fats and proteins and anxiety over an attenuated sociality are the pre-occupations of members of materially well-off social classes in the West. It is in terms of their perceptions of 'deviant' experience that cancer is understood. In the eighteenth century it was their counterparts whose wealth made possible the rise of medical practice as a professional skill. Standing for the first time between the individual and their death the presence of the doctor signalled the elitist status and wealth to which this social class aspired.

'Bad death' was death without medical intervention, the fate to which the poor and socially deprived were condemned.

The prevalence and complexity of cancer militates against distancing processes of this kind. Cancer is imaged as a stealthy, insidious invasion of the body, a 'malignant growth', the source and extent of which are hidden and unpredictable. Seemingly the equal vulnerablility of the organs is matched by the equal vulnerability of members of every social class. With the exception of an accepted medical link between cigarette smoking and lung cancer there are few isolated, category-specific behaviours commonly thought to cause cancer. Compare assumptions about the link between 'working-class' obesity or 'managerial' stress and heart disease.

In the absence of distancing strategies of this kind, the sense of vulnerability experienced by each and every individual is managed through a 'conspiracy of silence', the fostering of cancer's invisibility. As Sontag notes, an individual suffering from heart disease, whose death is, statistically, relatively imminent, may be freely informed of their condition. To inform the individual of a cancer diagnosis is not only to condemn but also to stigmatise the patient.[16]

The ideology of the Hospice Movement, which has arisen largely in response to the needs of cancer patients, can be seen to be linked with cancer's metaphoric associations with the perceived ills of our time. The Movement gained its most powerful recent momentum in 1967 through the setting up of St. Christopher's Hospice in London. Hospices have proliferated throughout the country since then. Significantly, it is the fund-raising activities of middle-class, often religious, communities which have been central to this proliferation. So effectively does the concept of Hospice care attract money that government policy[17] has been instituted in order to curb the charitable establishment of Hospices which the NHS is then pressured to maintain.

In a middle-class cultural and social context where repressed emotionality, social isolation, material excess and environmental pollution are seen as predominant social ills, the values brought together within the ideology of the Hospice Movement represent a readily accepted alternative. For example, pastoral care and counselling are provided for the 'important' purpose of helping patients get in touch with and come to terms with their own feelings. Indeed it is the range of emotional rather than bodily experience at the time of dying which has been the focus of Kubler-Ross's widely read work (1970;1975). Her writing/ counselling oriented towards 'the dying' is complemented by workshops for 'the living' where the expression of powerful negative emotion is a major focus. In addition to emotional openness the Hospice offers devoted care to each and every individual. The Hospice maxim, 'You matter because you are you',[18] resonates within a society where cancer is understood as the fate of a traumatically diminished self, finally ousted by alien disease cells. Similarly the management of a stigmatising disease by making it visible and evident is one of the Hospice Movement's particularly powerful gestures.

In summary an illness such as cancer which resists medical interpretations is currently imaged and conceptualised in terms of middle-class perceptions of social and psychological as well as well as bodily ills. Whenever cancer is diagnosed, medicine, which is grounded historically in the expending of middle-class wealth in the pursuit of status and privilege, is revealed as limited and fallible. Cancer cannot be distanced, either through medical intervention or through association with one particular social group or category such as 'the elderly', 'the working-class', 'the jet-setting executive'. As a result the myth of medical infallibility stands unmasked. What is thereby revealed or underscored is:

(1) the inevitability and unpredictability of each individual's death.

(2) the cultural and environmental rather than purely medical causes of death.

(3) class-based inequalities in wealth and in working and domestic conditions.

In remaining resistant to medical intervention, cancer not only reveals its limitations but also, consistently, brings home an awareness of the universality of human mortality. In Part Two of the thesis ethnographic material from a small hospice, recently established to the south of Stirling, exemplifies a set of innovative responses to such a state of awareness. Briefly I will introduce some of its central features.

3 MALIGNANT GROWTHS AND METAPHORIC EXPANSION

In Strathcarron Hospice in 1981, 128 of the 131 patients receiving care were suffering from cancer. The relationship between the Hospice and a more traditional medical approach is critical to the management of their care. The Hospice addresses itself to the limitations of traditional medical models, as they are revealed through the metaphoric associations of cancer.

The Hospice movement offers support to dying people in the form and pain and symptom control and extensive nursing and pastoral care. In comparison with traditional approaches, the breadth of this care reflects the richer and more expansive metaphoric framework of this Movement. Rather than an alternative, this framework can be seen as both an expansion and a transformation of traditional models.

Three aspects of cancer make it particularly difficult to incorporate the treatment of patients within a traditional medical model.

(1) Cancer patients are relatively young, large in number and suffering from an illness which is likely to be terminal at some stage. Of a total of 134,270 people who died from cancer in England and Wales in 1983, almost one half, 61,414, were less than seventy years old.[19]

(2) A patient's condition can often be diagnosed some months or even years before it slowly culminates in death.

(3) Their illness can take one of a considerable number of forms, the course of which is never entirely predictable. Symptoms vary and can be distressing.

In the face of this particular combination of attributes, the limitations of medical models become apparent. For example the customary attempt to halt or slow down the course of the illness can reveal medicine's most aggressive dimensions. Sontag notes the metaphors drawn from a military domain which are used in descriptions of treatment. On behalf of cancer 'victims', a 'fight', 'crusade' or 'war' is waged against the disease. 'Invasive', 'alien' or 'atavistic' cancer cells 'colonize' a body once 'defences' are lowered. 'Malignant' tumours can be 'bombarded' with radiotherapy or chemotherapy; 'radical' surgery is another possibility. Mutilations or amputations may be the only way in which the disease can be 'conquered'.

While such valiant attacks contribute to perceptions of cancer as a physical elaboration of political or military threats, the disease itself remains and is the cause of almost a quarter of all non-violent deaths. It is only by systematically obscuring the nature and incidence of cancer - i.e. by withholding

information and by removing patients from home to hospital - that the myth of medical infallibility can be upheld.

In turn this strategy of maintaining an uneasy silence itself reveals a marked discrepancy between refined diagnostic technology and confused moral or religious codes which offer few guidelines concerning the management of such knowledge and skill.

Finally, the suffering which cancer can entail is not easily acknowledged or managed through a system which interprets pain as a symptomatic by-product of diseases which can be cured. Chronic pain associated with cancer has been defined as a situation rather than an event and is described as unending, liable to increase, apparently meaningless and totally pre-occupying for the sufferer (Twycross, 1975:13). As Illich argues:

> Culture makes pain tolerable by integrating it into a meaningful system, cosmopolitan civilization detaches pain from any subjective or inter-subjective context in order to annihilate it. (1975:93)

The chronic pain associated with an incurable illness is a double challenge to 'cosmopolitan civilization'. Not only is it associated with a terminal illness and therefore medical failure but also, customary pain 'killers' may no longer annihilate pain in the way an individual has come to expect.

In Strathcarron Hospice three individuals skilled in the full range of traditional medical techniques are relieved of the doctor's implicit commitment to preventive or curative work. Their skills are used only to alleviate suffering which is acknowledged to lead to death. Once heroic, 'curative' techniques are foresworn, the removal of the patient from their social/domestic context is less necessary. The temporal boundary between initial diagnosis and biological death is freed from both the constraints of interventionist treatment and also the isolation of the 'terminal' ward where those 'on their way out',

'for whom there's no hope' are lied to by emotionally withdrawn relatives during rigid visiting hours. Being no longer set apart or exposed to surgery, individuals dying of cancer gain the opportunity to live as before. Their difficulties and their suffering, whether domestic, bodily, emotional or spiritual, can be managed with the help of an extensive body of hospice staff and volunteers. Movement into and out of the hospice is continuous.

For example, patients living at home may visit the hospice two or three times a week for daycare or may be admitted briefly for pain and symptom control; relatives visit freely and may spend nights in the hospice; patients dying in the hospice may make short excursions or longer visits both to their homes and to other places (shops, the countryside) which have been integral to their lives. No boundary lies between living space and dying space. The process of biological deterioration thus takes place alongside all the other processes which make up life.

In this way traditional medical models are both expanded and transformed. Though established skills and techniques are retained, their aims and objectives are transformed. Being firmly directed towards improving the quality rather than increasing the quantity of life, a 'medical' approach assumes the character of a collaborative rather than a combative strategy. This strategy is exemplified in the control of pain. Extraordinarily complex and refined technological procedures such as nerve blocking are consciously and deliberately complemented by counselling, cuddling and 'diversionary' approaches such as craftwork, gardening, music and travel.

4 SUMMARY

This chapter presents further material from a wider 'field' context, the media. I have indicated the dilemmas which it reflects, suggesting that they are associated with the management of health, life and death through a medical model. The power to maintain and to prolong very frail human lives, within a social context where an improved material quality of life is at least evident if not fully realised, raises questions concerning the quality of each individual life. Decisions about how such newfound power is to be used must take into account the need for a clear ethical framework which accommodates the varied circumstances of the individual.

Light is shed upon such dilemmas by the work of Illich, Berger and Sontag. Writing from the periphery they set the issues within a political context, showing the value of a broader perspective in the search for resolution of some kind. Though the power embodied in medical techniques produces a variety of conflicts it has nonetheless taken predominance over, and indeed masked, many of the broader cultural and social dimensions of human life.

While Illich (and Berger) argue that the narrow focus of a medical perspective effectively downplays inequalities in the distribution of wealth and the resulting quality of life, Sontag shows that an incurable, frequently encountered illness such as cancer reveals the limitations of this perspective and readily evokes the wider political implications of ill-health and its distribution.

Throughout this chapter (and Chapter 3) a historical perspective has made it possible to focus on the way in which one approach to the management of death has both gained ground and then given ground to its successor. I have selected the examples of a hospice and a bereavement support organisation in order to explore responses to the limitations of a medical model. In Part Two of the thesis field material from these contexts is set

alongside material from a residential home for elderly people. The resulting insights into contemporary practice show how universal experiences - of pain, physical and mental deterioration, and loss - are being framed within institutions which reflect the co-existence of both traditional and more innovative approaches to death.

NOTES

1. See Chapter One, pages 12 - 26.

2. See Chapter Three, page 71.

3. See Chapter One, pages 26 - 39.

4. See Chapter Three, pages 83 - 86.

5. Mortality Statistics: Review of the Registrar General on Deaths in England and Wales, 1984. DH1 No.16, page 14. Office of Population Censuses and Surveys, HMSO, 1986.

6. Annual Abstract of Statistics. No.120. HMSO: London, 1984. p.36.

7. See Chapter Three, pages 75 - 80.

8. The Times Health Supplement. 13.11.81., p.4.

9. The Times Health Supplement. 13.11.81, p.4.

10. Nichols, K. 'Since Nobody's Perfect'. Guardian, Society

Tomorrow. 4.5.83., p.13.

11. Bristol Cancer Help Centre, Grove House, Cornwallis Grove, Clifton, Bristol. The Centre's approach includes intensive counselling to promote positive thinking; relaxation; and a strict diet. Imagery techniques are used, involving the patient's capacity to fantasise that their own defence mechanisms are eating away a tumour.

12. Hertz makes this point, saying '...primitive peoples do not see death as a natural phenomenon: it is always due to the action of spiritual powers, either because the deceased has brought disaster upon himself by violating some taboo, or because an enemy has 'killed' him by means of spells or magical spells.'

13. The Order for the Burial of the Dead. In The Book of Common Prayer and Administration of the Sacraments...according to the use of the Church of England. A.R.Mowbray: London. pp.213-216.

14. Phillimore, P. Inequality and Premature Mortality in North Tyneside. Working title - in progress.

15. See Chapter One, pages 30 - 31.

16. Thus, for example, Strathcarron Hospice nurses working continuously with cancer patients were nonetheless startled to see the words 'Cancer Center' writ large on the side of an American hospital in a training video they were watching. (In America where the patient is also the customer, doctors give fuller information to avoid malpractice suits).

    Similarly, in the North East of England, 'Twilight Nurses'

(district nurses who give terminal care in the home), report extreme reluctance on the part of relatives and some general practitioners to utter either the word 'cancer' or the word 'morphine'. So firmly is morphine associated with cancer pain that the husband of a cancer patient shredded the tell-tale medicine boxes, disposing of them in plastic bags lest the dustman should make out the labels and gossip.

17. Terminal Care: report of a working group of the standing sub-committee on cancer of the standing medical advisory committee of the Central Health Services Council. Unpublished document presented to the Department of Health and Social Security in March, 1980.

18. Saunders, C. Care of the Dying. Macmillan Journals Ltd.: London, 1976. p.6.

19. Mortality Statistics. Cause. DH2, No.10. H.M.S.O.: London, 1983, pps. 6-7.

PART TWO

ENCOUNTERING DEATH: TERMINAL ILLNESS, OLD AGE, BEREAVEMENT

CHAPTER FIVE

ENCOUNTERING DEATH: THE USE OF THE SELF

As previously argued,[1] dying, like all other human biological processes, may variously be conceptualised and experienced according to the cultural frameworks of a particular society. Ethnographic material illustrated the range of conceptual categories through which death may be thought about; an initial discussion of ritual processes introduced some of the ways in which a particular quality of experience may come to arise.

The focus of the thesis is the human encounter with death. As such it expands upon existing understanding of how death may be thought about, adding to the existing body of ethnographic material; it also demonstrates ritual and symbolic processes associated with death as they are brought into play within our own society. It is through such processes that the human encounter with death comes into being.

In other words whatever the nature of the conceptual categories 'life' and 'death', their cultural and social meaning is experienced only in the enactment of a culturally specific elaboration of these biological processes which takes place in time and space. In the example of Strathcarron Hospice an ideology which has grown out of and in relation to the changing Western medical models of the last three centuries takes on its full meaning in the current performance of Hospice care, a performance which involves the slow persuasive process of bringing home an awareness of the imminence of death.

It will be argued that an appreciation of how processes such as these operate, and how a particular quality of experience is brought about, can arise only out of the active participation of the researcher within the process. It is within process alone that meaning is coming into being.

The earlier theme[2] of the relationship between an anthropological perspective and changing approaches to the management of death will now be pursued further. Moving into the particular contexts of fieldwork it will be shown how such a perspective may be acted upon.

1 SELF AWARENESS; ITS ROLE IN FIELDWORK

Using personal experience of fieldwork among elderly people as my primary example I will pursue the implications of the current boundary between life and death. An awareness of the self as a culturally and socially specific being is a critical aspect of creating knowledge about the process of maintaining and managing such a boundary - and about its implications for all aspects of contemporary human life in the West. As an 'insider', that is to say as an 'ageing' adult member of Western society, I am working within a field which extends into both my own personal history and into the world around me. Without an understanding of my place within that broad setting the knowledge which I might acquire would be ill-founded, ignoring the essentially interconnected, processual nature of cultural and social reality.

Previously[3] it was argued that the process of fieldwork itself was the source of anthropological knowledge. I suggested that entry into the experience of others opened up a variety of choices. The interpretive process involves the retrospective re-tracing of such choices and a recollection of the manner in which they were pursued or avoided. Hence concern lies with the question of choices.

Fieldwork can be seen as a responsive attitude or orientation towards the area of study - and not as a codified set of procedures. Accordingly the thesis contains no formal setting out of methods but, more appropriately, presents a developing

discussion[4] of an anthropological orientation towards, and within, the field of study. Responsiveness is by no means a purely intuitive or empathic following of one's nose within the field. Rather it is a state of cultivated flexibility grounded firmly in knowledge about the nature of knowledge. Choices both pre-figure and also extend into the events or activities which take place within the field. Discussion will focus first on the choice of field itself and the nature of the cultural and social categories which it involves or implies. Second it will address the choices which arise within or with respect to the field and which concern the nature of the working relationship between researcher and researched.

2 APPROACHING DEATH IN OLD AGE

The following joke turns up repeatedly in the back pages of magazines or on matchbox sleeves:

> Three old ladies were sitting on a park bench. One of them said "It's windy today, isn't it". "No, I think it's Thursday", her friend replied. "Well so am I", added the third old lady. "Let's go and have a cup of tea".

Elderly ladies, unsurprisingly, are seen to scramble distinctions of time, weather and bodily needs. And indeed the humour of this joke appears to be mild. It is nonetheless an example of ageism in that a supposedly harmless incompetence is unthinkingly assumed as an attribute of elderly women. Racist and sexist jokes usually refer to individuals who are permanently distant from the teller. By contrast ageist jokes evoke fearful possibilities which may constitute the future of the teller. Research among elderly people must involve a recognition of such jokes as one of the means by which fears about a future old age are metaphorically distanced and set to one side by younger adults. This calls to mind a whole network of jokes and stereotypes through which a conceptual separation is made between

adulthood and old age, between present and future. Prior to any research I stand, as an adult, in this relationship to elderly people. The quality of research therefore rests quite critically upon an ability to unravel and be conscious of that relationship and of the cultural metaphors through which it is constituted.

Issues of methodology and ethics are raised from the outset in work among elderly people. It involves a particularly strange and pressing configuration of questions concerning the study of human beings by their fellows. For example, whilst the bodily experience of elderly people may be barely conceivable to the adult researcher, their bodies do suggest what might lie ahead in old age. Furthermore on social, economic, political as well as personal levels much anxiety and apprehension is currently being aroused by the approaching spectre of an evergrowing body of infirm and unproductive elderly people. Such images lend an increasing urgency to the problem and policy oriented studies which predominate in the field of gerontological research. A literature review reveals this orientation in titles such as 'The Social Challenge of Ageing' (Hobman,1978), 'The Measure of Need in Old People' (Isaacs & Neville,1976), 'The Social Medicine of Old Age' (Sheldon,1948), 'and 'The Care of the Elderly in the Community' (Williams,1979). More emotively there are titles such as 'Sans Everything' (Robb,1967), 'Old and Alone' (Tunstall, 1966), 'The Last Refuge' (Townsend,1964) and 'Old and Cold' (Wicks,1978).

Thus gerontological research can involve experiences which prompt the researcher to speculate upon the possibly disturbing nature of their own future - and, simultaneously, involves contact with members of a social category perceived to be a challenge or even a threat to society as a whole.

3 THE 'PROBLEM OF THE ELDERLY'

Thane traces the history of the 'problem of the elderly', showing that it came into being as recently as the late nineteenth century (1983:191-198). Prior to this period adults worked for as long as they felt able. Under the 1834 Poor Law their support during any remaining years was the responsibility of their family. Charitable almshouses and workhouses accommodated those without family. Only with the advent of increasing trade pressure from abroad in the final decades of that century was enforced retirement introduced. Employers were thus able to shed older and less productive workers and for the first time elderly people came to be perceived as a large, separate category, dependent upon society in general rather than upon their own families. As in the case of the social category 'child' the gradual beaurocratising of the system of wage labour has led to the creation of a separate or marginal non-wage earning social category.

Phillipson argues for a subsequent link between ambiguous attitudes towards retirement and the economic priorities of employers.[5] It is his view that economic fluctuations are reflected in a changing image of retirement. He differentiates between the image of old age as enfeeblement which predominated during the depression prior to World War Two and the ideological pressures to delay retirement during the boom years of the 1960's. More recent attempts to promote images of buoyant senior citizens with railcard and membership of the University of the Third Age[6] can be seen to coincide with massive increases in unemployment.

When set within the context of a post-industrialised society the objectives of much gerontological research begin to take on a particular significance. Thane and Phillipson show the problem of the elderly to be one of the outcomes of an intensifed competitiveness associated with the process of industrialisation.

The demands made upon an economy under pressure from abroad by the members of unproductive social categories can be seen to be met through the same control-oriented perspectives which underpinned the process of industrialisation itself. Thus while gerontological research encompasses a variety of research methods, the social survey nonetheless predominates. Moreover, given that increasing dependency is countered primarily through support of a practical kind, it is the extent and nature of material needs among elderly people which predominates as the focus of research. Tinker notes that:

> ...the social surveys of the late 1950's, the 1960's and the 1970's were concerned first with the relationship between need and provision and secondly with the importance of taking into account informal networks as well as state provision. (1981:18-19)

She goes on to note that 'the medical aspect still continues to take a central place in the literature', pointing out that the authors of a number of standard works on social aspects of ageing are doctors rather than sociologists (1981:20).

Thus the main body of gerontological research is couched in problem and policy oriented terms. Its credibility arises from accurate assessment and measurement of what might be called 'the facts of the matter' - i.e.provision for need and resource allocation.

Nonetheless, despite a strong commitment to identifying, quantifying and remedying problems of a practical kind, the emotional dimension of this work, for both researched and researcher, does make itself felt. For those involved in survey work through questionnaire and interviewing it is an often unwieldy dimension, both in collecting and interpreting material. For example, Life Satisfaction tests were administered in geriatric wards by Evers[7] and in a residential home for elderly people by Clough (1981:34). Once put into practise Evers found

their use was found to be not only inappropriate but distressing and abandoned them completely. She also abandoned plans for interviewing, finding that replies tended to be monosyllabic. Clough draws attention to the 'ethnocentric' concept of Life Satisfaction through which younger adults have formulated such tests. While he did make some use of such tests he points out that they are a better measure of Life Dissatisfaction, that elderly people cannot be expected to be happy in situations which are 'demonstrably miserable and unsatisfactory'.

Similarly Willcocks, in the synopsis of a paper entitled 'Evaluating the consumer view of residential care', reports that:

> We discovered at the pilot stage that residents tend to be acquiescent and passive; they are reluctant or unable to provide critical comment on a residential setting, and they found it difficult to express preferences.

Material was finally acquired by compiling a cartoon card pack containing twenty-seven items depicting various aspects of residential care provision. Residents then arranged the cards in order of preference. Willcocks writes:

> With these cards we played our 'ideal home' game in one hundred homes with some one thousand elderly residents. (1981)

In this way the need for extensive sampling demanded by quantitative research was satisfied.

The difficulties encountered in these three examples are not uncommon. They can be seen to arise from a pressing need for 'objectivity'. Wenger, investigating the experience of loneliness among elderly people, writes in the abstract of her paper of:

> ...a new scale which attempts to overcome problems of stigma and denial in data collection.

She notes that:

> The definition of loneliness has, however, remained problematic and it is therefore difficult to assess just what is being measured when the subject is discussed. (1983:160)

Wenger points out that it is large sample studies which convince central government funding bodies of the representativeness of results. She suggests that in-depth, time-consuming studies might be more fruitful. I suggest that were she able to pursue a study of this kind the apparently 'problematic' issues of definition, denial and stigma might offer critical and indeed very fruitful avenues into the quality of experience of elderly people.

Thus, although the emotional dimension of gerontological research makes itself felt repeatedly, it is the perception of elderly people as members of a needy social category which consistently reinforces the hegemony of 'objective' research. In order to allocate resources appropriately, research must provide an 'objective' assessment of the true nature of their condition. As Okely notes, the traditional means of ensuring 'objectivity' is to eradicate the link between researcher and researched (1975:171-188). This can be achieved through the use of pre-determined sets of questions such as Life Satisfaction tests. Extensive sampling is similarly effective in that confrontation between researcher and researched is mediated by large groups of assistants who generally do not design or modify the questionnaires, or analyse the data. It appears that human intervention was avoided entirely in 1962 when, in Tunstall's words, 'the Government Social Survey interviewed 4,000 old people in Britain' (1966:4). As an alternative to precluding the

possibility of a subjective response on the part of the researcher through the use of such distancing techniques, Okely advocates that the researcher cultivate an awareness of their particularity as a cultural and social being. In this way the significance and the implications of their own responses can be properly understood and made use of in subsequent interpretation.

In the field of gerontological research the traditional objectifying techniques of separation and distancing are not only of dubious merit but also indicative of the deeply problematic nature of the relationship between these particular categories of researcher and researched. In a sociological thesis Fairhurst describes the use of participant observation in a rehabilitation unit for geriatric patients. She writes explicitly of:

> ...the results of declining physical functioning such as incontinence, brain damage and ulcerated legs (which) are unpleasant for one human being to witness in another. (1981:95)

She goes on to say that:

> It is precisely because unpleasant aspects of doing research on the elderly, particularly those in hospitals, are inextricably linked with the notion of personal experience that arguably accounts, at least in part, for the relatively few ethnographies on old age. The concern with resource allocation, be it in terms of medical or social services, in many studies of old age is an example of what Roth (1962) has termed 'management bias' on the part of social scientists. (1981:97)

Thus in contexts such as geriatric homes and hospitals the personal feelings of the researcher can be brought powerfully into play. The quantification of survey material can be understood not only in terms of a spurious search for 'objectivity' but also as an important self-protecting strategy used by those whose sensibilities are inevitably assailed by their informants. The 'humourously' aggressive titles given to

conference papers such as Ford's:

> Dissecting the Elderly: Forging a new Sociological Tool.(1982)

indicate the researcher's very personal need to arm themselves against the emotional onslaught of material of this kind. As I will show, personal responses of this kind have a weight and a significance which is often overlooked. They are intrinsic to the relationship between younger adults and elderly people and therefore of value to those who seek to explore that relationship.

This discussion has shown that the choices which arise with respect to both the topic and the methods of research are points of entry into a critical debate about the relationship between researcher and researched and about the cultural and social grounding of social science research. Its underpinning is the post-Cartesian analytic world view[8] which has predominated in the West since 1600 and which facilitates control of the world's natural resources. As shown in the example of policy-oriented gerontological research, a fluid social world created and re-created through the participation of its individual members is often subsumed within the static de- personalising categories of power-holders - those who seek to control and to create order among the unproductive members of politically and economically competitive Western societies.

Distances are induced within the shared experience of human growth and decline in such a way that the identity of both researcher and researched can become depersonalised. As in the parallel examples of ethnic minorities such as gypsies, or deviant social categories such as criminals, their 'awkward' individuality is threatened by such a method. In consequence deviousness or silence may be their only defence.

4 CHOICE WITHIN THE FIELD

The creating of alternatives to traditional social science methods involves attention to the role of metaphor in human understanding. In this way the personal and apparently subjective responses of both researcher and researched can be encompassed. As noted,[9] Lakoff and Johnson argue that human beings do not experience and understand the world in which they live in a direct fashion but rather through an inherited system of cultural constructs, specific to their own society (1980). According to this thesis the knowledge and understanding which is sought within the human sciences does not correspond directly to series of discrete objects which have an independent existence in the physical world. Rather research of this kind is the process of extending the metaphoric concepts or models through which an apparently objective 'reality' is conceived of and created. The focus of research must therefore be re-appraised. The world of absolutes, of verifiable truths amenable to direct scientific description, assessment or quantification is revealed as illusory. In its place can be substituted, as a more appropriate focus, the metaphoric concepts through which the members of other cultures or other social categories think about and experience the world and their place within it.

With respect to gerontological research there are those who resist an objective approach which has been developed for the purposes of isolating and identifying specific 'facts' and their inherent properties. They argue that it offers an inadequate and unsatisfactory account of human understanding, language and values and often turn to embrace the alternative, subjectivist myth. Perceived as an alternative, the subjectivist myth nonetheless similarly presupposes the world to be made up of separate properties. Its orientation is the responses of the individual to such a world. Implicit within this myth are the

ideas that such responses are particular to the individual, that they are matters of intuition, emotion or imagination. That is to say, they are not to be understood as part of a rational, structured whole which extends beyond the particularity of the individual. As Fairhurst points out in reviewing one of the few ethnographies of old age:

> Those of us who want to flesh out the literature by gaining a feel of the experience of being old often turn to the autobiographical or semi-autobiographical works of such individuals as Ellen Newton, Gladys Elder, Jane Tulloch or the novelist Barbara Pym. (1981b:138)

In a similar vein Johnson questions the appropriateness of research which assumes a commonality of experience among elderly people and gives little acknowledgement of individual response to circumstance. He advocates a 'biographical approach', concluding his discussion by saying of the elderly individual:

> ...it is the subjective view which has shaped his life and led to its present position. His worries, failures, fond memories, satisfactions, frustrations and pride are all his own self-estimates and part of cumulative self-image - all thoroughly 'non-objective'. (1978:99-113)

Thus the dichotomy between objectivist and subjectivist myths is consolidated. The resort to autobiography or isolated, retrospective accounts of personal experience reveals the presupposition that human beings respond in an individual, even idiosyncratic way to a physical world which is made up of separate and discrete entities, each with its own inherent properties.

Myerhoff similarly went as far as to seek to re-create the conditions of old age within her own body as part of fieldwork among elderly Jewish people living in Los Angeles (1978:18). Thus she would walk to the old people's centre without glasses,

wearing ear plugs and her heaviest shoes. While, as a Jew herself, she admits to gaining much through this rehearsal of her own future, such an exercise cannot, of itself, reveal the cultural systems through which such physical conditions are experienced by those for whom they are permanent.

Participant observation, the extended involvement of a researcher within the world of the researched, is grounded in the assumption that individual experience may better be understood in terms of the rational, structured and creative metaphoric concepts through which human beings think and act within the world. As noted earlier, frail elderly people are often seen to represent an undesirable or frightening future condition for the younger adult - and also constitute a social category which for historical reasons has come to be dependent upon that category of younger, working adults. In asserting the potency of the metaphoric concepts through which 'reality' is framed, Lakoff and Johnson point out:

> ...whether in national politics or in everyday interraction, people in power get to impose their metaphors. (1980:157)

To understand the dependency of today's category of elderly people (and institutionalized elderly people) in purely material terms is to ignore their more profound vulnerability to the potency of the metaphoric concepts of the younger adult. Given that those engaged in gerontological research are members of that more powerful social category, it is critical that work pursued in this area should arise out of and take full account of the nature of that relationship.

Discussion among anthropologists with respect to fieldwork suggests ways in which the'adult'/'elderly', 'researcher'/ 'researched' relationship can be explored through participant observation.

Geertz adamantly refutes:

> ...the myth of the chameleon fieldworker perfectly self-tuned to his exotic surroundings - a walking miracle of empathy, tact, patience and cosmopolitanism. (1977:481)

Adherring to the view that understanding or perception can occur only 'with', 'by means of' or 'through' systems of a symbolic semiotic or metaphoric nature, Geertz concludes that to immerse oneself in the inner life of the informant is to discover that:

> ...ideas and the realities they disclose are naturally and indissolubly bound up together. (1977:482)

Uncritical empathy or an over-flexible personal style are dangerous in that the fieldworker may unknowingly assimilate the already disclosed reality of informants without necessarily becoming aware of the system of concepts through which that reality is shaped and framed. The alternative suggested by Geertz is a process of 'tacking back and forth' between everyday immediacies and the over-arching concepts which frame them. In other words, the meaning of acts or utterances can be read from their reference within a given context.

Jackson echoes Geertz's warning that a system of ideas is inextricably emmeshed within the experience which it makes possible (1983). He offers a critique of an over-intellectualist interpretation of bodily experience, arguing that meaning cannot be read into sets of movements, such as dance; they are not to be seen as a physical or symbolic representation of a conceptual system. Rather they are to be understood within the context of an entire range of bodily movements, the environment of practical activities which Bourdieu calls the habitus (1977). Like Geertz, Jackson is therefore arguing for the embodied, experiential nature of a metaphoric system. Unlike

Geertz he seeks knowledge of such a system from within, through complete participation or, after Bourdieu, 'practical mimesis'. Experiences such as making the transition from his own to his informant's style of fire-lighting lead Jackson to suggest that:

> ...by using one's body in the same way as others in the same environment, one finds oneself informed by an understanding which may then be interpreted according to one's custom or bent, yet which remains grounded in a field of practical activity and thereby remains consonant with the experience of those among whom one has lived. (1983:340-341)

Thus two rather different approaches emerge, both informed by the idea that effective research focusses on the metaphoric system through which informants perceive and experience reality.

Whatever the relationship which arises between the two categories of researcher and researched, it can be seen as particular to the categories through which each perceives the other. As a result many would argue that a rigid exercising of decision or choice on the part of the researcher is mistaken, that their roles or relationships will be negotiated over time by and within the field. Nonetheless it is precisely through the relationship between self and other that understanding becomes possible. As already established, those involved in research among elderly people stand in a far from easy or uncomplicated relationship to their informants. In this respect they share the experience of any anthropologist who works among the members of social categories rendered less powerful through the capacity of members of their own social class to impose control - for example among prisoners or vagrants. Similarly their experience has parallels with that of any anthropologist who seeks to reveal the metaphoric systems through which the members of other, more powerful social categories retain their control - for example feminist anthropologists working among male-dominated elitist groups.

As I have argued, a relationship of some kind links all researchers and the social categories or groups among whom they work. When the field lies close at hand, where a shared language is in use, and where an asymetrical relationship of power pertains between researcher and researched, the insiderhood of the fieldworker is often a problematic and confusing circumstance. As noted the jokes and indeed the entire metaphoric system through which a less powerful social category such as 'the elderly' are perceived may be a far from obvious aspect of the fieldworker's personal world view. Thus the language used unthinkingly by the fieldworker may take on a whole new set of meanings to the ears of those whose experience-in-the-(shared) world is nonetheless of an entirely different nature - for example if their freedom is curtailed through imprisonment; if their sense of self is deteriorating rapidly through an advancing illness. While the fieldworker makes free metaphoric use of bodily experience such as health, mobility, or sight - for example **"I'm sick to death of this wet weather"**, **"I'd better run along now"**, **"I see what you mean"** - the elderly or criminal person, now deprived of such experience may be acutely aware of the literal rather than figurative meaning of such a turn of phrase.

For example a hospice volunteer, wrestling with a badly-tangled bundle of cane, sought to encourage persistence among a group of would-be basket makers/dying patients through the inspirational metaphor, **"Never say die !"** Her unthinking choice of metaphor resonated awkwardly, taking on at least three literal meanings which were quite specific to the context of the hospice. First, the Hospice Movement is committed to finding acceptable ways of 'saying die'. Second, the bald 'saying of die' is nonetheless inappropriate in that the Movement seeks to facilitate acceptance rather than cause fear among patients. Third, to be able 'never to say die' and to escape mortality may, at least at times, be the heartfelt desire of many patients.

It is often remarked that the English and the Americans are divided by a shared language. Meaning is imbedded within, and arises out of, its lived context. For those whose life within that context is dwindling rapidly the meaning of language can be dramatically transformed. In cases such as this I feel that deliberate and self-conscious choices are critical.

Just takes up this point (1978:81-97), suggesting that for those who work within their own society:

> ...the task is to take the accepted and common-sensical and, by some (other) process of 'translation', to render it momentarily strange and bizarre so that we might seek to understand it. (1978:85)

This description leads me to suggest that Geertz's diffidence about embracing native experience may not be appropriate when it comes to working within one's own culture. Just goes on to say that for those, such as Geertz, who work abroad:

> ...the task was to encounter the seemingly strange and bizarre and, by a process of 'cultural translation' render it acceptable to 'common sense' so that we might understand it. (1978:85)

Just's choice of the word 'encounter' is apt. For anthropologists working abroad the strange and bizarre immediacies, the unfamiliar concepts, are encountered with a force (if not clarity) which is impossible for those working among groups already 'known' and 'classified' according to their own values and assumptions. I would argue that only participation facilitates a genuinely anthropological account of the metaphoric systems of that group or category. The richer and more extensive one's own cultural perspectives with respect to a particular social group or category, the more necessary an experiential approach becomes in gaining access to both our own and their conceptual systems. The use of role play in teaching

or therapeutic situations is an acknowledgement of this principle, where the aim is limited to the discovery of 'what it actually feels like' to be the other, too well-known individual. The anthropologist's aim however is to question or explore the pre-conceptions of familiar social catgories, to engage in a learning process which is essentially incomplete. That is to say, 'immersion', as a venture, hinges critically upon an ability to do so in a partial and self-conscious manner. It is thus that the 'critical lack of fit', from which Ardener describes the anthropological experience as deriving (1971:xvii), can deliberately be constructed by those working among more familiar social groups. In the case of fieldwork within a residential home for elderly people the decision to participate can raise further questions.

Of relevance here is the term 'practical mastery', used by Bourdieu (1977) to describe the competence of an individual to pursue their own intentions through negotiation and manipulation of the dispositions of their own culture. It is above all a mode of operating which stems from a learned ignorance or lack of awareness within the individual as to the generative principles from which their cultural style derives. For reasons which I go on to discuss I sought to elucidate the generative principles from which cultural styles derive in this social context through a partial and self-conscious attempt to assume the 'practical mastery' of the insider/care aid.

As already suggested, certain key factors lead to the decision to immerse oneself fairly deeply, indeed in this case to step into one of the institution's inherent roles. The question of familiarity has already been raised. From my own point of view, that of a member of the same society, a residential home for elderly people appears to fall very much into the category of 'the accepted and the commonsensical'. Many of the values and assumptions which hold sway in such an institution have echoed through the schools and the hospitals which make up my own

personal history. Similarly child-care and housework have been the occupations through which I have defined myself throughout an extended period of my early life. Nonetheless I was aware that the apparent 'ordinariness' of institutional life represented a very particular mode of managing the 'non-ordinary' processes of deterioration and death. It seemed clear that an understanding of such a mode could be acquired only through extensive participation in the fine grain of that 'ordinariness'.

Through learning the skills and taking on the tasks of a care aid for a period of nine months I encountered the confusions and the pitfalls of performing hitherto familiar tasks such as bedmaking and bathing, table-laying and toileting in an unfamiliar role, responsible for elderly and often incapable strangers rather than youthful relatives. These experiences were common to each novice care worker, uncomfortable but fleeting. For the fieldworker these experiences are material to be grasped, stored and sifted over. With every blunder and hesitation the gap between personal assumptions and the priorities of the institution widens. Through careful reflection each can be made to stand and be known in sharp contrast to the other. In this way a critical lack of fit comes to arise, by virtue of the fieldworker's deliberate and self-conscious cultivation of a sense of personal disorientation.

Through this method the conditions of old age, from immobility and incontinence to depression and confusion became the pressing focus of all my energy and attention - physical, emotional and intellectual. Deeply familiar tasks of cleaning and bathing, conversing and coercing, were no longer framed and defined by the personal, the private and the domestic world of family. The movement back and forth between the home and my home effectively re-oriented my understanding of the significance of these aspects of life for a very different category of dependents.

In addition the outcome of my initial meeting with the Matron (i.e. that I was offered the role of care-aid) is revealing in itself. I have shown that this role allowed me an oblique view of familiar caring tasks without which I may have interpreted what I saw purely in terms of my own private domestic experience. In addition this role was perceived by staff, by residents and by me as comfortably in keeping with my past experience as a professionally untrained wife and mother. The management of death in old age emerged as a process for which my role as female parent qualified me. Had I been male; had I been medically qualified; had I been employed by the local social services research department, I might have chosen or been placed in a quite different role. As it was, the perceived appropriateness of my gender and parental experience for the task of caring for elderly people gives immediate insights into the cultural and social framing of the process.

In contrast with an anthropologist working outside Western society I crossed only the subtlest of boundaries in my role as care-aid. The ease with which I could accept a lowly status, menial tasks and a minimum of responsibility - and the readiness of staff and residents to accept a woman who displayed both warmth and willingness - are aspects of fieldwork which reveal much about the system within which I worked.

By contrast hospice staff offered me the role not of domestic or orderly but of voluntary driver and 'companion' to less ailing patients. As I will go on to show in greater detail, power is located more centrally within the hospice and the boundary between hospice and home is deliberately softened and made fluid. Pervaded throughout by a middle-class ethos, the hospice made ready use of middle-aged, middle-class women such as myself, placing them at the periphery as 'front women' whose presence promoted an atmosphere which was both warm yet dignified. Within the residential home for elderly people I remained at the centre of the institution, at a safe distance from the Matron and her

powerful position at the Home's periphery. While the residential home made use of my domestic experience and was wary of my social class, the hospice made use of my social class, whilst offering me little menial work. Both made use of my gender.

Further questions to be considered when making choices about the nature of participation concern the kind of knowledge one seeks to acquire. In certain contexts interviewing and direct questioning are appropriate, particularly if implicit metaphoric systems have been transformed and objectified in an explicit form such as a folk ideology. In a residential home for elderly people practical mastery prevails. Its 'ordinariness' is the product of a culturally contrived, socially maintained ignorance of the home's 'non-ordinary' function - the channelling of deteriorating human beings towards their deaths. Thus the struggle to administer formal tests reveals that much of what goes on and much that is critical within this context cannot be articulated. Indeed the problems encountered in eliciting verbal statements give vital insights into how a culture of care is constructed.

An example of the aspects of this culture to be borne in mind is the fact that while elderly people and younger adults are perceived as members of separate social categories, standing in an asymetrical relationship of power to one another, 'elderly' is a social category within which surviving younger adults will eventually find a place. Frail elderly people represent the unattractive aspect of otherwise desirable longevity. Thus, within the confines of the residential home, the giving of domestic and nursing care by adults to elderly people is a process fraught with ambiguity. Though institutionally powerful, care staff are drawn close and involved within the experience of members of a social category customarily set at at social, conceptual and spatial distance. Furthermore the implacable nature of the ageing process means that the exercise of power by staff is ultimately limited and constrained by the physical and

mental condition of those in their care. Questions of dependency and of the the exercise of power are therefore not only central but also of a complex and far from clear cut nature in such a context.

It has been observed that those who care for elderly people are unique among health and welfare employees in their lack of formal training and instruction. My own ease of access to the role of care aid underscores this point. The disintegrating order of very elderly lives, like the yet-to-be-integrated disorder of infant behaviour and the ever-unravelling order of the private home, is the province of informal, unqualified female labour. It is through women's personal, unmediated work that the self-perpetuating forms of domestic disorder which lie on the margins of a formal, economically productive adult world, are continuously transformed into an orderly system. Clough notes the ambiguous and vague terms in which even senior staff describe the aims of residential care workers - i.e. 'keeping the residents happy' and 'giving them care' (1981:141). Often there is no external structure or programme to chart the process through which each worker acquires the skills intrinsic to the carer's role. In such a setting ideas and the realities they disclose are not only indissolubly bound up together, but also remain largely implicit, being learnt through and retained within the body. By remaining largely inaccessible to the conscious mind, the constraints and the paradoxes of the 'care staff' role are managed if not overcome.

Another aspect of the culture of care which has important implications for research methods is the structural dependency and physical weakness of those admitted to care which mitigates against their being able to express or even conceptualise alternatives to their present circumstances. In their frailty, residents perceive the authority represented by capable staff as a necessity rather than an imposition. Nonetheless residents retain some scope for power in their own infirmities. The

partial immobility, deafness or incontinence brought about by the ageing process can become a resource to be deployed sporadically when dependency irks most. A slumped body or a deaf ear are effective and direct statements which mutely assert that which rarely finds form in thought or word.

In summary, my participation in a culture of care may seem to approximate to what Geertz describes as 'swimming in the stream of native experience' (1977:482). I employed none of the distancing techniques of structured interviewing or surveying but instead involved myself, often through action rather than words, with staff and residents. Nonetheless 'the stream of native experience' was not the place I swam in. My field location was the human encounter with death, the conceptual, social, spatial and temporal boundary between life and death where my informants, ageing, dying and bereaved, discovered themselves. My approach represents a process of conscious decision-making, a particular interpretation of the cluster of ideas and approaches known as participant observation. In a context such as the residential home, that which Bourdieu describes as 'symbolic and cultural capital' (1977) is objectified primarily within the body as it moves through the confined and carefully structured space which is the home. In order to apprehend that which is learned only in practice and reaches the level of discourse only in humour and allusion, I made use of my own body. By intercepting otherwise imperceptible processes of transmission I was able to transform my pre-existing understanding of ageing.

Three events which took place in connection with elderly people illustrate the insights made possible through deliberate interception of this kind. It is significant that only one of the three actually took place within the space known as the old people's home. Each event was enacted at a different time and in a separate space. Each one involved physical and emotional participation on my part. It was participation of this kind which allowed me to perceive the shared system of cultural

metaphors embodied within each one. My subsequent intellectual juxtaposing of the events rests upon the prior decision to assume a degree of practical mastery within the residential home.

> (1) Travelling north on a long distance coach I shared a double seat with an elderly woman. Close by the window, she slept deeply for a large part of the journey. Without warning an attack of sickness disrupted her sleep and she struggled in confusion to recover her dentures amidst the vomit. Lacking both social skills and a cloth of any kind, I looked immediately to my fellow passengers along the aisle. All stared intently towards their own windows. My proximity to the event was taken to indicate that responsibility for its management remained with me. Somehow the woman and I recovered ourselves with a few mumbles and a small handful of tissues.
>
> (2) (from fieldnotes made on the eleventh day of fieldwork in the residential home) After lunch the new care aid and I had to get a resident, Winnie, now in sick bay, up and into a chair. Winnie appeared fast asleep and, on awakening, resolutely insisted that she wasn't getting up. Attempts to persuade her, uncover her, were countered by Winnie going limp and apparently going back to sleep. I felt at a loss and went out to get advice or help. I came back in, finding no-one around, and the care aid laughed, saying that Winnie had woken up as soon as she heard the door close, thinking we both had left. The care aid suddenly became assertive, refusing Winnie's insistence on staying in bed. Her deep-voiced, North eastern **"Howay Winnie, howay !"** surprised me as the rather silent girl, only sixteen years old, had given no warning of her confidence in dealing with these matters. I followed her lead and we heaved the inert, soaking-wet Winnie into a sitting position and forced her clothes onto her limp body.
>
> (3) Shortly after completing fieldwork in the residential home I spent time staying with a relative. Late one evening her elderly neighbour sought our help as his companion, a woman in her eighties, had been brought home distressed after a heavy fall in the street. My relative asked if I would go in with her and I found the woman on the neighbour's settee in considerable pain, crying, vomiting and urinating. Though my relative and her neighbour were familiar and therefore closer to the woman, I moved into the situation unhesitatingly,

> making tea, finding and holding a bucket for vomit and organising an ambulance. Meanwhile my relative, an able and forceful mother of five, and her neighbour, a constant companion to the woman, did very little. Unlike the event on the coach this was a situation in which I was in no way the obvious member of the group to assume responsibility. Nonetheless the entire trio ceded control to me, commenting as they watched on how well I coped.

How are the accounts of these three events to be read? Written in the first person they demonstrate a changing personal response to very similar situations. To show how such experiences illuminate a sphere far wider than the purely personal and introspective I will explore their relationship to one another in time and space. If the second event is assumed to be the only true field experience, then the residential home itself is being mistakenly perceived as the focus of study. This assumption implies an objectivist stance in that the institution is being seen as a discrete entity, amenable to direct study. While the home's spatial boundary is indeed important, it is not as a limit to the sphere of study, but rather as an embodiment of conceptual boundaries which divide up the biological continuum of human life, creating widely separated social categories. This is the perspective from which an anthropologist, participating within an area of their own society can make themselves aware of and indeed exploit the familiarity of their own cultural and social categories.

For example, in the second account, my involvement in the role of care aid was total in that, unreservedly, I assumed responsibility for getting Winnie up. Nonetheless I approached her in a polite and distant style of my own. It cut very little ice. Winnie successfully outmaneouvred me and the care aid, a member of my daughter's generation, was prompted to demonstrate the appropriate and effective cultural style of the institution. Through physically assisting the girl I absorbed directly a little of this style myself. The anthropological value of the incident is however discovered retrospectively. It lies in the

deliberate if uncomfortable opposing of two styles, one being an elaboration of working class style within the inner world of the institution and one being an example of the middle class world of the university outside. Though the opposition occurred in the 'field', it was about the relationship between inner and outer worlds and the boundaries which separate them. By allowing the mismatch between my assumed role and my personal style as a member of an educated middle class to become evident and to take its course I was able to explore this relationship.

My polite and distant style would have been unremarkable in any middle class woman finding herself in unfamiliar proximity to a urine-soaked and decrepit stranger. It demonstrates a considerable cultural investment in concepts such as privacy, freedom and social equality, these being expressed in direct confrontation with a member of a social category customarily contained and set apart from the world of healthy and affluent adults.

As for the care aid, she was new to the home but six months voluntary work with elderly patients in the nearby hospital had been sufficient for her to absorb the assertively familiar style of low-ranking NHS employees when dealing with less-esteemed categories of patients. For those employed in this way, making people do what is required of them is frequently understood through metaphors such as 'its for your own good', 'sometimes you have to be cruel to be kind' and 'we all have to go through it'. Such metaphors highlight areas of the experience such as bodily welfare and the inevitability of pain or discomfort. They also conceal or downplay other areas such as loss of privacy and loss of adult status. The power of these metaphors is reflected in the effectively assertive style of the care aid. They preclude any hesitancy or diffidence which might diffuse her authority or complicate the maneouvre she was attempting.

Some days after the event described I was again involved in getting Winnie up. This time I worked with Jan, a slightly older and more experienced staff member. In speech and gesture Jan gave still more subtle and effective form to metaphors of this kind. She approached Winnie, gently patting her cheek and telling her we were getting her up. Then came a swift, rhetorical **"Any objections ?"** Having thus established that Winnie's getting up would take place, she left to find stockings. It was then possible for me to sit Winnie up without difficulty. As we worked, Winnie's odd remarks, **"I'm fed up"**, **"I'm no good at all"** were countered by the reply, **"Well that makes two of us Winnie"**, from Jan who had overslept that morning.

In summary this preliminary reading of the second event shows how my participation produces an interraction which is more fruitful than mere observation might be. The narrowness and the particularity of the care aid's metaphors are revealed when set in contrast, through action, with my own. The reverse is also true. My own metaphors or cultural categories which otherwise might distance or distort my understanding are not only made evident but can also be recognised as an aspect of the total social situation which has given rise to institutions such as the residential home.

As my familiarity with the field increased I, like other novices, absorbed the embodied metaphors of residential care. Though my style was lacking in the authenticity of those committed to the role of carer, events such as the third one described reveal that much had been internalised. Reflection upon the details of this event, particularly in comparison with the first event, throw yet more light upon what can be called the meaning of residential care for elderly people. It was clear that the physical and emotional condition of the elderly woman in the third example was perceived by her companion and his neighbour to be chaotic and disordered. It was something which they felt hesitant about

dealing with, despite their relationship with her and their competence in other areas of life. In this respect their behaviour resembled my own and that of my fellow passengers in the first event. Had I not recently been working in the residential home I too would undoubtedly have extended the chaos by deferring to my already muddled relative and her neighbour before offering help or advice. As it was I not only shared their perception of the woman as disordered but also had access, within myself, to the metaphoric systems through which such disorder is categorised and contained within our society. In other words, in so far as the woman's particular distress would have been perceived as an entirely 'ordinary' event on the inside of the institution, so the institutional mode of speech and behaviour through which I took control of the situation was accepted as entirely authentic by these three members of the wider society.

5 SUMMARY

In summary the institution known as the residential home can be understood as an embodiment of pervasive cultural metaphors through which the ageing process is perceived and ordered. Apparently mild matchbox sleeve jokes such as the example cited earlier subtly underscore a reality in which the younger adult implicitly perceives the very elderly person as belonging to a separate, set apart and different social category. In this way the evershrinking temporal interval between our present and our possibly frightening future selves is transformed into an enduring, intractable social and spatial divide.

The three events I have described are all examples of this particular form of distance and social segregation expressed in bodily style. As case studies they show the heuristic possibilities of a self-conscious process of immersion within the categories of the institution. For example, the contrasts and

oppositions which occur within and between each event facilitate an understanding of the way in which particular areas of human experience come to be perceived as culturally and socially disordering. Among the three women, the third was undoubtedly suffering the most acute physical and emotional distress. Yet my re-ordering of the situation involved possibly less in terms of gross physical intervention than either of the two preceeding events. It was through my use of a particular cultural style of speech and movement that all those present came to feel that incipient chaos was now controlled. Rather than diagnosing or relieving the pain in the women's shoulder, the apparently immediate problem, I was primarily giving shape to an unscripted situation, directing or guiding this trio of individuals through an experience which lay well beyond the bounds of their everyday relationships with one another. Indeed without the performance of embodied metaphors of the kind I have described, the chaos described in the first event holds uncomfortable sway.

In this chapter I have argued for an awareness, on the part of the researcher, of the self as a cultural and social being. This is particularly important when fieldwork is pursued within the researcher's own society. When the focus of study is a social category such as 'the elderly' it becomes critical.

As I have shown, the relationship between the categories 'adult' and 'elderly' is characterised by tension and anxiety. Both the fabric of the residential home and the cultural style of those employed as careworkers are embodiments of pervading cultural metaphors through which the experience of old age is perceived by the younger adult. Bearing in mind Lakoff and Johnson's assertion that it is the powerful who succeed in imposing their metaphors (1980:157), it must be recognised that elderly people are not only perceived through particular sets of metaphors but, more significantly, their very experience is shaped by the power of younger adults to impose those metaphors upon them. Though the adult human being is separated from their own old age only by

an everdwindling temporal interval, there is an implicit but consistent cultural strategy of distancing and separation in operation between the categories 'adult' and 'elderly'. In this way a temporal link is transformed into a social and spatial divide. Through ageist jokes, a category perceived to be as separate as 'female' is from 'male' and 'black' from 'white' is created.

Similarly there is a proliferation of gerontological research carried out through the quantification of data collected by extensive survey work. In this case the traditional techniques of severing the link between researcher and researched do not merely foster the myth of academically respectable objectivism; they also ensure the maintenance of a boundary between the social categories 'adult' and 'elderly'. Through participant observation I was confronted, as a fieldworker, with the physical, emotional and social quality of this relationship. Using three case studies I have demonstrated the systems of distancing and control through which the relationship is maintained. Concluding a review of literature on ageing Tinker remarks that:

> ...another matter which has so far been little touched upon is what the elderly themselves wish. (1981:24)

If such a perspective is to be acquired the cultural and social divide which lies between the known present and the unknown future self must first be encountered and then come to terms with.

In the chapters to follow the nature of this divide is explored more extensively. With research methods as my primary focus I have introduced the metaphoric systems through which younger adults create and maintain a present/future separation. These systems must be seen in the context of the less powerful but nonetheless insistent metaphoric framing which, for example, the

memories of elderly people may provide for an increasingly uncertain present. If the matter of what elderly people themselves wish, or think or feel, is to make itself felt then the relationship between past time and present time which is specific to their own experience must be elucidated. From the perspective of younger adults the encounter with death is often managed through control over the distance between present self and possibly deteriorating future self. From the perspective of frail elderly people the encounter with death is often managed through the careful and consistent metaphoric transformation of a dissolving present, one which draws on the extensive store of images which lie in a very lengthy past life.

NOTES

1. See Chapter One.

2. See Chapter Two, pages 50 - 60.

3. See Chapter Two, pages 51 - 53.

4. Chapters 2 and 5.

5. Phillipson, C. The Emergence of Retirement. Working Papers in Sociology. University of Durham.

6. The University of the Third Age describes a recent French initiative to offer university courses to elderly people. Some 160 universities in Western Europe are involved. An example is a spring semester programme at Stirling University where subjects such as modern languages, politics and the

philosophy are offered.

7. 'Work and Organisation in Geriatric Wards'. Talk given in Newcastle Health Research Unit, October 1982.

8. See Chapter Three, pages 82 - 86.

9. See Chapter One, pages 27-32 and Chapter Two, pages 49-51.

CHAPTER SIX

LIMINALITY AND THE CREATION OF 'NON-ORDINARY' TIMES AND SPACES

Both a residential home for elderly people and a hospice are non-ordinary places which render liminal the time of dying. However, the culture of each one is different and gives particular forms and qualities to the experience. In both contexts issues such as the changing experience of the self, the power to give care and to impose control, and the maintenance and the breaching of a 'life'/'death' boundary, emerge continuously - but take radically different forms. Even very similar comments made with respect to those approaching death take on very different meanings when uttered in one or the other context. For example

(1) **"You know they're pampered here, they're really pampered."**

(2) **"They're really spoiled here, they deserve it."**

These two sentences are statements made by staff about people who are likely to die in the near future. Statement (1) was uttered in a residential home for elderly people and invokes the fictive notion that very elderly people are not approaching death - and therefore do not have special needs. Statement (2) is an inversion of (1) and was uttered in a hospice. It acknowledges the literal reality that patients in the hospice are dying and that they do have special needs.

The following sentences are remarks addressed by staff to the same categories of people.

(1) **"I'll carry you both out on my back."**

(2) **"I'll carry you home on my back, you're so tiny."**

Sentence (1) was uttered in a residential home for elderly people. It is a teasing remark which obliquely alludes to the physical condition of two elderly women and the limitations of the care which staff offer. The speaker was a small, slight porter/handyman and the women he addressed were large and immobile. Sentence (2) is another teasing remark in that this speaker too will not do what she promises. It was uttered in a hospice however and does refer directly to the physical condition of the patient and implicitly to the idea that the nurse can support the woman through her frailty.

In each of these two pairs of sentences the sense is virtually identical, yet their utterance in one or the other of two very different social contexts alters their reference very significantly. Both institutions are located within a society where death and its associations are avoided and distanced as frightening, disordering and therefore powerful events and ideas. In part this strategy of distancing rests upon the expertise of the social category 'doctors' in keeping people alive - so contributing towards a pervasive and uneasy illusion of personal immortality. This illusion has been noted in the popular press[1] where an American writer is quoted as saying that although he knew death was universal, he'd always assumed an exception would be made in his case. In addition medical expertise can also yield unforeseen yet indisputable revelations of individual mortality in the form of diagnoses of terminal illness. This particular combination of circumstances, the effective yet inevitably limited medical control of a socially and culturally disordering event, is an important part of what goes on in the different cultures of the residential home and the hospice.

The very presence of the residential home represents an avoidance of deterioration and death. In this institution very elderly people are drawn aside from home, work, family and friends into a

space which is peripheral to the rest of society. As forty-five people encounter death in a confined and peripheral space, the powerful and frightening aspects of the event are disguised and modified through institutional strategies entirely in keeping with the prevailing cultural and social strategy of keeping death at a distance. In such a setting these strategies play upon the ambiguities of a medical framing of human life and death. The accumulation of ailments which frequently brings death to an elderly person does not lend itself to a single and definitive diagnosis of terminal illness. An illusion of immortality, however shaky, continues to be fostered, here in a rigidly structured and repetitive present which is set apart from the past, present and future, the here-and-now of the world outside the home. Staff's vigilance in maintaining the unobtrusiveness of a passage between entry (life) and exit (death) - and the corresponding uniformity of their jokes, deflections and silences attests to the potentially disruptive power of the event of death.

The Hospice Movement is an alternative cultural elaboration of the medical framing of human life and death. The dilemma introduced by current diagnostic skills, 'to tell or not to tell the patient that they are dying', provides part of the spring-board for the ideology of hospice care. In a society enmeshed in a half-conscious illusion of personal immortality, the advent of a sense of mortality may often be brought about only through the authorised voice of the diagnosing consultant. The consultant, being able to acquire knowledge about the nature and timing of an individual's death, controls that knowledge and reveals or withholds it according to their persuasion. When this position of power is coupled with expertise in pain and symptom control, the circumstances which are elaborated in the culture of Hospice care can be seen to have arisen.

1 CONSTRUCTING PLACES FOR DYING

A residential home and a hospice, two non-ordinary places within which dying occurs, will now be explored. As established,[2] living space and dying space has come to be differentiated within our own society. 'Making separations', 'setting apart' and 'the creation of the sacred' are closely interlinked cultural and social strategies, all of them associated with those aspects of human life which lie outside the carefully structured categories through which the environment, individuals, and their experience are ordered. On some level all are strategies oriented towards the management of process - for example transition from one social category to another; from one calendrical period to another; from one area of thought and experience to another. Movement may be between conceptual categories - from the sacred to the secular; social categories - from adolescence to adulthood; or material categories - from summer to autumn, from life to death. Movement of one kind rarely occurs without the invoking of all three.

The emergence in the West of a 'scientific' world view, which involved a rigid if limited analytic framework, has already been discussed.[3] The relationship between enduring rules, roles and categories and shifting cyclical processes takes on a new complexion within such a system. The anthropological study of ritual forms has shown them to be both constituted from and constitutive of the fabric of everyday interraction.[4] The idea and the experience of process arises out of the ritual manipulation of the material or literal substance of society's root metaphors - in such a way that boundaries between categories may be both dangerously breached and then safely re-created. Where everyday life is managed through reducing or limiting knowledge to that which is proven and that which is controllable, the condensed material/metaphoric resources for the complex ritual process of re-orienting transient human beings may be

minimal. In the current separating of dying from living it is the authenticity of a static image of life as enduring 'adulthood' which is maintained. The process of transition from 'adulthood' to old age, deterioration and death is downplayed in a setting apart which involves no reintegrative process.

A residential home for elderly people and a hospice both involve the separation of living and dying. Within each space death is the ultimate reference of all that occurs. The structuring of them both will be discussed in order to show that their orientations towards the process of dying and the event of death differ markedly and, in each case, a very particular quality of experience comes into being.

2 HIGHFIELD HOUSE: A RESIDENTIAL HOME FOR ELDERLY PEOPLE

In this institution the Local Authority houses forty-five elderly people who cause concern or experience difficulty in living alone or with younger family in the outside world. Most of them have applied for admission and the majority are accommodated in their own single bed-sitting rooms. Carpet-tiled, with teak bedside furniture, wardrobe and built in wash-hand basin and mirror, the rooms overlook lawns, trees and flowerbeds at the periphery of the city. Most of the home's elderly residents bring favourite ornaments, photographs and religious pictures or objects in with them. Some bring their own armchair, rug or small table and, together with pot plants, these valued possessions fill the light sunny bed-sitting rooms. Small lounges and alcoves are also available for the elderly people to sit together and there are three televisions for them to watch. Meals are waitress-served at small tables in a dining-room where floor to ceiling windows open onto the gardens.

There are other services offered. Rooms are cleaned regularly and thoroughly, and bed-linen and personal clothing are laundered and returned to rooms. If anyone becomes ill or unable to get about, care assistants give nursing care or assist with bathing or walking. When elderly people come to live in the home they give up their own private accommodation, knowing that they will be able to stay on in the home for the rest of their lives.

The forty-five elderly people living in the home during my nine month period of fieldwork often needed help from a care assistant. Many of them were very old, born some years before the Boer War, one or two being already in their mid teens at the time of Queen Victoria's death. More than half were over eighty-five years old and most were over seventy-five. While sixteen of them needed little special help, ten could walk only with a zimmer frame and therefore had to be bathed by care assistants. Seven people could not communicate easily, either through deafness, stroke or confusion and a further twelve could neither communicate nor walk with ease. Three women were totally immobile without a care assistant's help and five experienced either occasional or permanent incontinence. Within ten months of my initial entry into the home approximately a quarter of the elderly people I met had died, usually within the home itself.

The home's material circumstances, as described above, lend themselves to the maintenance of an attractive image of the homeliness, security and independence of 'adulthood'. However the mental and physical losses experienced or observed by the elderly people living together at close quarters are an unequivocal representation of biological processes which lie outside the curative frameworks of medicine. Indeed they are peripheral to the prevailing cultural categories of both 'life' and 'death'.

The residential home is therefore a dying space concerned primarily with process. Whilst admission is made available only to individuals deemed incapable of independence, their life within the home may be a lengthy process.

Not only are the illnesses of old age often chronic rather than acute, they are also accompanied in many cases by other gradual losses such as blindness, baldness and immobility. Death itself tends to arrive slowly, from a multiplicity of ailments rather than a single and specific disease. McDonald expands upon this point when she describes the quality of her experience of being seventy years old.

> One doesn't just die all of a sudden. It is a process and one we may be conscious of for the last ten or twenty years of our life, which if you think about it, may be a quarter or more of your lifetime. I find myself wondering why this is not more talked about and why it has not become the common knowledge of our lives. I am self conscious in writing this. For after all, no one speaks of dying until they have only a few months or weeks or hours to live. This is society's definition of dying. It asks that I deceive myself and others about my daily awareness that my body is using itself up; it prevents me from calling this process by name for myself and others. (1984:108-109)

McDonald is acknowledging her entry into a social category to which many negatively perceived aspects of bodily existence are now implicitly distanced in the West. They range from a (sexually) unattractive appearance, an inactive body and an unreliable memory through to incontinence, dementia and death. The occurrence of any one of these conditions prior to old age is recognised as at best a misfortune, at worst a tragedy. Indeed the wholeness of the adult is made questionable through the presence of one or more of these conditions. Distanced to old age such conditions are kept firmly in place through the silence required of older people.

Within the residential home the process of ageing is submerged. The role of the Matron is critical to its submersion. Spatially, temporally and hierarchically she is so located as to be able to promote a figurative representation of a homely enviroment which may then be used to transform the experiences identified by McDonald as 'dying'. Those elements of the home and its inhabitants which approximate to the cultural categories 'life' and 'adulthood' are selectively highlighted through metaphoric strategies which simultaneously downplay evidence of the slow collapse, 'dying'. Only when the 'deadness' of an elderly person is finally given open acknowledgement through coffin, hearse, undertaker and flowers, do some of the elderly inhabitants and care staff of the home watch and possibly follow the body to the funeral.

The role of the Matron stands in opposition to the role of her care staff. The authority vested in this role is expressed in her social and spatial distance from staff - and from residents. For example, while she and her two deputies have exclusive use of a matching dinner and tea service, staff bring in their own mugs kept in a separate cupboard in the kitchen. Eating and relaxing similarly take place in separate rooms - Matron's office and the Staff Room - and indeed during sequences of duty the Matron lives in a flat within the home. Similarly her white uniform dress contrasts with care staff's blue-checked overalls - and her personal clothing is laundered within the home where a machine will be put on solely for a few items of her clothing rather than including them in a larger load of residents' laundry.

Set apart in this way she is distanced from the literal evidence of residents' increasing physical frailty, conditions which she possesses the medical and administrative capacity to exercise some control over. She can be compared with her staff whose daily tasks of washing, dressing, bedmaking and managing meal times involve constant exposure to human frailty and decay.

Unlike the Matron, staff lack nursing qualifications and are given no medical information concerning the condition of those in their care. In addition they lack her authority to draw directly upon the expertise of outside agencies such as doctors and the hospital. While the Matron may re-create the conditions necessary for the imposition of the categories 'life' and 'death' upon an ageing population, staff's work involves them continuously in the tension between the figurative and the literal reality prevailing within the home.

2.1 The Matron as Sentinel

The Matron spends much of her working life at a desk facing the ever-open door of her office. From this position she looks out into a carpeted foyer where a coffee table with flowers and magazines stands surrounded by armchairs and pictures. She faces the home's locked glass entrance door and, beyond it, the three-sided entry courtyard. From the courtyard a curving drive leads away towards the main road and two neighbouring institutions, County Hall and the local hospital, both of them closely related to life within the home. Beyond lies the city.

The courtyard is fairly well-hidden from the main road. It allows for access of all kinds. New residents, visiting family and friends, staff, doctors, health care officials, food, rubbish and the dead all pass into and out of the home through this space. The Matron has visual control over it.

Away to the right of the Matron's office the foyer leads off towards a complex of rooms comprising the staff room, kitchens, washing and ironing rooms, the medical room and the dining-room. Once past this space the carpeted foyer gives way to the long lino-tiled corridors along which are lined the thirty single and seven double bed-sitting rooms where the elderly people live.

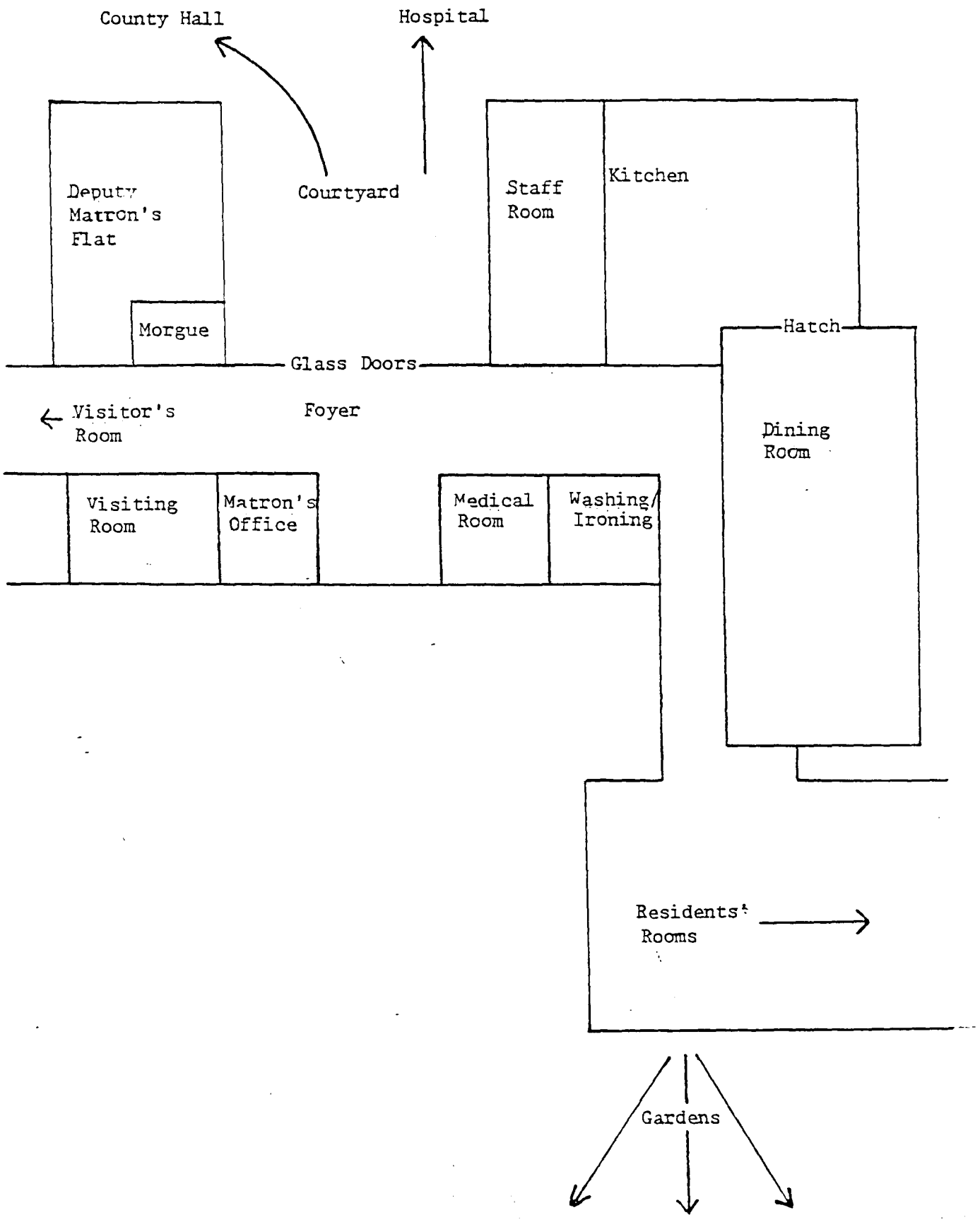

Figure 1: The Structuring of Space at the Periphery of Highfield House.

The diagram illustrates the spatial relationship between Highfield House and the outside world as it is mediated by the Matron. While some residents' rooms occupy similar space on the floor directly above the foyer, only two have visual access to the courtyard.

To the left of the Matron the foyer gives access to a small visitor's room, a lounge (used irregularly by a small group of elderly women and by day-care visitors), and the two sets of double doors leading to the morgue. Beyond and also above the morgue lie two flats, the upstairs one belonging to the Matron and the other used by her two deputies.

Thus the rooms overlooking and bounding the courtyard on three sides are the Matron's flat, the foyer, the staff room and just two of the thirty-seven bed-sitting rooms where the elderly people live. The remaining thirty-five of their rooms face away outwards towards the gardens and the countryside to the northwest of the city. This form of spatial organisation is illustrated in the accompanying diagram.

2.2 Controlling the Care.

Located at the periphery of the home the Matron is responsible for admitting elderly people to the home. This process leaves her in possession of a great deal of medical, social and financial information concerning the individual. While they live in the home she holds their pension book, their medicines and their valuables in her office. She will also have determined just how many clothes, ornaments and small items of furniture they have brought in with them.

The Matron's involvement with the elderly people who have 'settled' in the home as its 'residents' is more limited. She may administer medicine in the dining-room after a meal. Very occasionally she will serve the main course at lunch time, carefully selecting the food according to her knowledge of each individual's preferences. She will sit over breakfast with a resident on their birthday and open and read out their cards while admiring the carnation button-hole they have been given by the home. Last thing at night sometimes she will say goodnight to residents in bed in their rooms, blowing them a kiss where appropriate.

It is when an elderly person living in the home becomes ill that the Matron again becomes involved more directly with them. She will go in to visit them in their room and summon their doctor if necessary. If they become very ill and are about to die the Matron may sit with them through the night in the downstairs sickbay and deal with their immediate relatives. When a resident dies she usually lays out their body, packing its orifices and bandaging the feet together. The removal of the body from the sick bay (or a resident's room) may also be managed by the Matron, she overseeing the maintenance of secrecy as staff usher living residents into their rooms. Her final contact with the elderly person is when she releases their body from the morgue under her flat to the undertaker in the courtyard. Relatives deemed inattentive during the resident's lifetime may also find that the Matron seeks to retain some control over the elderly person even after death.

For example when a resident's two neices and a nephew appeared for the first time at her funeral their behaviour was interpreted by staff as cold and ungrateful. **"Its their guilt"** they said. The Matron declared herself all the more determined that the resident should have a headstone and that she was going to have Masses said for her - that would use up a bit more of her remaining money (and keep it from her undeserving family).

2.3 Metaphoric Scene-shifting: 'The Homely Here-and-Now'

As forty-five elderly people edge their individual ways forwards to death in the homely here-and-now of Highfield House the Matron effects critical shifts of meaning within their immediate environment. As indicated she operates at a fixed distance from the processes they are undergoing. This suggests that the home's boundary, the Matron's stable position, is the point from which power emanates. A figurative set of meanings created at the periphery provide an interpretive framework for all that goes on within.

Ricoeur's work on the referential meaning or meaning-in-the world of a text and, in addition, of action read as text, provides insights into this process.[5] He argues that discourse, written down as text, has both an internal or sense meaning and also a referential meaning which transcends the limits of the text itself. The sense meaning can be thought of as an internal self-referential, semiotic system. It makes sense or has meaning purely within its own terms. Referential meaning stems from the relationship between text (or action) and the world. It concerns what the text discloses of the world through its being in the world. In addition reference concerns the meanings accruing to the internal relations of the text by virtue of their location within the time and space of the world.

The literal referential meaning of daily life within the home is that forty-five people have lived so long as to have outgrown their places within the outside world. They are now separated from a past life and from the roles and relationships through which it was constituted. In addition their bodies have begun to change, in some cases fairly rapidly, in ways which can only lead to their death. For the first time in their lives they are without the prospect of future change - that is change other than the gradual physical deterioration which, in most cases, will take place within the home up to the time of their deaths. The domestic and nursing services which elderly people are offered in the home are a way of managing the practicalities of this process of deterioration which takes place without the constant support or intervention of family or friends belonging to the past. It is the Matron however who transforms the home's literal referential meaning, supplying in its place a figurative set of meanings associated with homeliness, security and independence. Located at the periphery she is well placed to make interventions in the relationship between the internal system of the home and its referential meaning-in-the-world. Speaking of language, Ricoeur describes it in terms such as:

> In the phenomenon of the sentence, language passes outside itself; reference is the mark of the self-transcendence of language.
>
> Language is intentional par excellence; it aims beyond itself. (1978:74)

He also points out that the French word 'sens' not only means 'meaning' but also 'direction' or 'orientation' (1978:161).

In other words to realise the semiology of a language system in the form of the text is to bring about the inexorable shift from sense to reference, from semiotics to semantics. By analogy, to allow 'connections' to be made within the home concerning the past life which has gone and the future life which is to come is to bring about a swift and painful awareness of the literal referential meaning of a timeless, endlessly repetitive present of meal-times, bath-times and bed-times.

The residential home is both subsumed within and constituted through 'boundaries' of a kind which inhibit the making of connections. They are critical in the transformation of the literal referential meaning of the home. In this condensed world of ageing and dying there is an essential introduction of distances between people and things, ideas and knowledge and, ultimately, 'life' and 'death'. The widest gulf lies between the home itself and the world outside. The containment of the home within such a gulf or boundary is the necessary condition for the continuous mis-reading of the referential meaning of the confined internal system. It is at this boundary point that the Matron is to be found. It is from here that she controls both the broad external boundary of the courtyard and also the lesser, more complex bounding of the time and the space within.

The Matron is thus well-placed to intervene in the shift from sense to reference and to promote the figurative transformation of the processes of ageing and dying which are essentially under

her control. It is a figurative representation of the home which the Matron exposes to an external world of family, visitors and health workers. They in turn, being in many cases involved with or responsible for the admission of an elderly person, willingly accept and reflect back to her the figurative representation which she offers. In this way a cultural strategy of metaphoric transformation which is essential to the ethos of 'care' can be seen to emanate from a carefully controlled dialogue which takes place at the periphery of the home, at a safe social and spatial distance from the powerful literal reality which it seeks to transform.

In summary the residential home is a space visibly set apart, which has a quite specific role or purpose. Unlike almost any other single-purpose building or institution it is a true cul-de-sac where future alternatives are lacking. In this respect it stands in an iconic relationship to human biological existence which, regardless of a society's processual twists and turns, leads inevitably to a single event, death. In the bounded, condensed space of Highfield House an awareness of the transitory, mortal nature of life, customarly diffused through a cultural stressing of development and accumulation, is brought home. Like acts or utterances staged within a proscenium arch, living in residential care readily assumes a non-ordinary reference - i.e. 'a matter of life and death'. And, bearing the extra-ordinarily loaded referential capacity of any ritual or indeed any stage production, its meaning is susceptible to the power of director, shaman or Matron. Like the writer's critical choice of one word rather than another within the dozen or so lines of a poem, the Matron's manipulation of one event or one individual has an extensive resonance within the condensed semantic space of the residential home.

In this first example of a dying place I have drawn attention to the role of a boundary or frame in the creation of a time and a space within which events or acts acquire expressive power, the

meaning of which is open to manipulation. An environment peopled within by heavily wrinkled, immobile or confused individuals is a powerful evocation of death. When carefully controlled the literal meaning of such conditions can be transformed - and a figurative state of homely independence can be fostered. In such a context 'pampering' comes to be seen as a form of care which is both unwarranted and inappropriate.

Within a hospice, a very different 'non-ordinary' place, a similar form of care, 'spoiling', has an entirely different resonance. Like the residential home the hospice is space singled out from the rest of life for a specific purpose. Here too death is the endpoint or ultimate reference of every event, utterance or act. The care offered because 'they deserve it' implies no individual merit but, rather, a common diagnosis of terminal illness. While this implication goes without saying, the context within which it is uttered provides a silent completion of the sentence.

What was revealed within the residential home were the processes through which a fictive 'ordinariness' is fostered within a 'non-ordinary' social context. Walking frames, deaf ears, ungovernable limbs and sterilised plastic beakers all are continuously transformed into a semblance of well-regulated independent adulthood. In the hospice transformative processes of a very different kind are in operation. Rather than a continuous shift of meaning away from a literal, 'non-ordinary' process to a figurative state of 'ordinariness', the hospice embodies strategies through which an 'ordinary' place, a mansion built to accommodate a former way of family life, is being continuously transformed into a 'non-ordinary' space where dying is the explicit focus of all that goes on.

3 HOSPICE CARE: THE EXAMPLE OF STRATHCARRON

In a society where a precisely defined separation between living and dying is maintained, the Hospice Movement seeks to reintegrate the two categories of experience, thereby highlighting the processual nature of their relationship. This intent has been pursued through the creation of buildings explicitly oriented towards the care of dying people. That there appears to be a paradoxical dimension to this strategy has been noted by its opponents. In Newcastle (1979), at a public meeting about proposals for a new hospice, points were raised by those who felt such a venture might threaten their own budgets. Using the example of an existing Marie Curie Home for terminal cancer patients it was argued that separate spaces for dying raised patients' anxieties; that hospices segregated the dying and placed death outside the experience of most doctors and nurses; that a hospice made death more of mystery and a special case.

As already indicated, process is an area of experience which is often managed through the cultural strategy of setting apart carefully framed times and spaces. In our own society where 'growth' means accumulation rather than change, those processes associated with loss and decline are managed within separate spaced devoted largely to the distancing and transforming of otherwise threatening aspects of life. Thus in the residential home the material resources of daily life outside institutional space are made use of in metaphoric strategies which conceal rather than reveal the 'non-ordinary' processes framed within this space. Rather than the deepening of an individual's awareness through ritual exposure to the experiential substance of a society's root metaphors, the central material experiences of adulthood, such as shared meals and a room of one's own, are so re-produced as to create a fictive 'ordinariness' which diverts awareness from the biological processes which are taking place.

Though given little explicit acknowledgement, deterioration nonetheless remains visible and dying becomes conspicuous by virtue of its invisibility. Entry into separate spaces of this kind indeed inspire fear in that biological processes of decay are so transformed as to represent a form of social death, a fate which effectively severs connections between an individual and their former social roles within the wider society. In this respect an institution such as the residential home must be seen as a special case, one which deviates markedly from the wider body of ritual times and spaces through which process is elsewhere incorporated within the patterning of the social fabric.

The hospice however can be seen to lie firmly within that wider body of ritual or liminal times and spaces. Its commitment to the reintegration of life and death is achieved precisely through a carefully framed encounter with death, one which becomes possible within the very deliberately structured environment of the hospice.

Previously[6] I used the analogy of the stage to discuss the framing of ritual time and space. Certain factors pre-disposed the participant to respond to the inherent power of the symbolic forms contained within that space. These included an awareness or recognition of the special nature of that space and a willingness to accept as authentic the authority which it embodies. When these dispositions exist within the participant the apparently mundane objects, social roles and behaviours contained within spaces set apart for special (i.e. religious, theatrical, healing) purposes begin to take on the power of symbols. In the case of a hospice, internal features such as the structuring of ward space, the organisation of timetables and the dress, bearing and style of staff together evoke a set of meanings which effectively transcend the day-to-day immediacy of uncomfortable symptoms of disease and strained family

relationships.

The material to follow shows how traditional sources of power are appropriated - and fused - within a space set aside for dying. These sources include the authority of traditional medical models, the continuing respect commanded by religious values, and ideas about a worthy heritage from the past.

Thus the transformation of Randolph House, a family mansion in Stirlingshire, and the resulting construction of Strathcarron Hospice can be seen as the creation of a space within which the symbolising power contained within 'ordinary' cultural and social forms may be brought into effect. In this context traditional sources of power are being brought to bear upon a unique situation. The deaths which are now occurring within Strathcarron Hospice might, until recently, have taken place within the isolating context of intrusive, curative medical technology. Inversions of the customary spatial and conceptual separation of the living and the dying are therefore continuously being introduced through the practise of Hospice care. The powerful associations of medicine, of religion, and of death are being brought together within this institution. Through the framework provided by Hospice ideology the power of each one is manipulated and made use of in quite specific ways.

3.1 Setting the Stage.

Strathcarron Hospice is founded in a large family home formerly known as Randolph Hill Mansion and, until 1978, the property of the family of a local paper mill owner. Roadside gateposts mark the beginning of a curving driveway which leads the visitor past lawns and rhododendrons to end in a broad flourish before double doors enclosed in a pillared porch. The family's high panelled reception rooms at this public end of the mansion give way to smaller domestic rooms, kitchens and outhouses, extending away downwards towards the river Carron which crosses the grounds behind further banks of rhododendrons. The processes through

which this family mansion has been transformed into Strathcarron Hospice give insights into the particular cultural framing of death which it represents.

As I will show it is an institution where the idea and the event of death is acknowledged more openly than is customary and where its painful and frightening aspects are confronted rather than distanced or avoided. The framing of space within and around Strathcarron Hospice, and the relationship between the hospice and the surrounding community indicate the ways in which a particular kind of openness is being sought.

The primary material alterations to the original building include the extension of the back of the house to provide three small wards to accommodate up to thirteen patients, the setting up of a mortuary and the modification of cooking and laundry facilities. The original, extensive wood-panelling and an elaborate, intricately carved staircase darken the wards and the reception area - and require careful cleaning. Nonetheless, as the trappings of an earlier wealth and respectability, their evocative power is retained in the creation of a dignified mode of dying.

The transformation, indeed inversion, of the name of the mansion gives clear indications as to the particular cultural elaboration of dying and death which takes shape in these modified spatial arrangements. The name of the river, 'Carron', little more than a stream, unobtrusive below the furthest domestic and outhouse buildings, is now displayed prominently in decorative blue lettering on a large white signboard at the entry gateposts. Replacing the former title, 'Randolph Hill Mansion', the word 'Carron' takes the prefix 'strath', meaning valley. In approaching the building, set on the rise of a hill, the patient, doctor or visitor is now entering a river valley. This image, evoked in the re-naming of the building, is echoed in an outline drawing of outstretched hands, wrists together, the heavier lines

on the underside of the hands suggesting the valley. The word and the drawing, placed together on the signboard, affirm the image.

Through this signboard the presence of the hospice in the small Stirlingshire town, Denny, is made public and visible. In its form, the sign encompasses an allusion to nearby water in which the images of caring hands and a river valley are fused. In addition, the river valley, 'Strathcarron', is the seventeenth century name of the region. Now fallen into disuse, this name has been reintroduced, thereby stressing links between the present and the past, between contemporary hospices for the dying and medieval 'hospyces', or way stations, for pilgrims.[7] Death and the care of the dying is thus being given prominence, in a very particular form.

The chosen imagery, of water, carries extensive associations, particularly with respect to Christianity. These range from its use as a specific Christian symbol of purification, baptism and re-birth - through to its extensive metaphoric use in giving form to such concepts as flow, tranquillity and peace. For those who enter the hospice, members of a society where a Christian ideology remains pervasive, water and its associated forms of the river and the valley retain powerful if non-specific meanings. In its broad yet very vague associations, water offers an effective fund of images through which the culture of care may be organised and articulated.

Entry to the hospice is now by way of new glass doors approximately halfway along the building. These have supplanted the original porched entrance door. To the left of these doors lie the three wards (two former reception rooms and an extension) which accommodate up to thirteen dying patients from any part of the central region of Scotland. These wards are named 'Aven', 'Endrick' and 'Devon', the three rivers which bound this region on the north, west and east sides. The patient's death will

occur in one of these three wards and their body will then be taken along the building, past the glass entry doors, the kitchen and the laundry, until it reaches the mortuary behind double doors at the far end of the building. In two parts, the mortuary comprises first a single, velvet-draped viewing room and then a simple storage room with pallets and a fridge for up to six bodies. This viewing room, the body's final public destination, is named the 'Carron' room. Lifecourse and deathcourse are thus made continuous in the patient's transition from periphery to centre, from their life in the Central Region to their death by the River Carron.

Senior staff, the administrator and a GP, responsible for naming the rooms, are vague about the reasons for their choices. The administrator, a former University chaplain, considered the possibility of using the names of mountains but finally chose rivers as **"living, symbols of life"**. He is aware that the Aven, Endrick and Devon bound the region to which the hospice's care is available.

An exploration of the relationship between the hospice and the surrounding communities reveals a further reflection of the choices made in the ordering, through naming, of the interior of the building. The image of a valley which both encloses and channels aptly represents the relationship between Strathcarron and the Central Region. Of the history of the hospice the administrator told me that its present medical director floated the idea of a hospice in 1975. Despite the absence of deliberate fund-raising, repeated public meetings led to the accumulation of sixty thousand pounds within three years, and the name 'Strathcarron Hospice' became synonymous with terminal illness. Almost every aspect of the life of the hospice now involves a circular flow or movement, of people, money and gifts from all parts of the region in towards the focal point of the hospice and back out again.

The association of this open flow with the coming of death is indeed a transformation of prevailing practice which confines death to the isolation of hospital side-rooms and the seclusion of old people's homes. The openness begins with some kind of communication of medical information between consultant and patient, a strict pre-requisite for referral to Strathcarron. It is extended in the repeated visits of a hospice GP, a Macmillan home-care nurse and a social worker to the home of the patient and their family. From this point onwards a volunteer may drive the patient and their family to the hospice for short-term admission or for regular day-care visits. The latter comprise up to five hours spent in the day-care room where conversation, music and craft activities are available. Permanent admission occurs only if death is imminent and family can no longer support the patient at home.

After the patient's death their family, particularly spouses, may receive bereavement visits from their volunteer 'driver'. They may also return at least once every month to the hospice to meet similarly bereaved people at an 'At Home' evening. Such visiting may continue well into the second year after the loss and as time passes the circle of bereaved people grows. While no charge whatsoever is made by the hospice to patients and their relatives, money and gifts are often donated 'in memoriam' by families. Similarly the daughters and wives of deceased patients often volunteer their domestic or nursing skills in the years following the death. Gift-giving is not restricted to bereaved people. Wedding bouquets and the middle tiers of wedding cakes are now being offered by those marrying within the region. Money flows into the hospice from many sources. These range from grants from Local Councils and the Health Board to the contributions of Central Region Council employees who donate between 2p and 10p of their weekly wage.

Thus the relationship between Strathcarron and the surrounding communities can be described as an open channelling of resources which makes possible the provision of extensive and very flexible care of dying people. So sought after and respected has this kind of care become that, as local people admit, of the several collecting boxes ranged on the pub bar, Strathcarron's always receives the small change. Staff at local hospitals are quick to provide seating and attention should a Strathcarron patient, openly 'terminal', require such treatment as an eye appointment.

Such a channelling of resources is made possible through the direct acknowledgement of death, one particular elaboration of the accurate medical diagnosing of illnesses such as cancer. This form of elaboration represents a deliberate choice. The carefully chosen imagery through which this choice is represented has multiple references. The linking together of the rivers at the periphery and at the centre of the hospice's sphere of operation, and the fusion of the valley with the caring hands are expressive on two levels.

The first, already discussed, is the flow or movement of money and people towards the hospice which is integral to its functioning. Patients and visitors are given a sheet with descriptions of exact routes to the hospice from seven different directions. Public signs to Strathcarron are prominent in the local town of Denny. In seeking to entertain patients and bring in further funds, staff jogged around the perimeter path of the Hospice in preparation for a 'marathon' which involved relay teams of eight staff assembling at four points sixteen miles away from Strathcarron in each direction. Again the movement from periphery to centre was traced, this time through the runners and the sponsor money which they brought in as they raced back to the hospice.

The second way in which the imagery operates is through its explicit visibility, an inversion of the distancing of death which is elsewhere pervasive. The transformation of Randoph Hill Mansion has involved the placing of the name of the unobtrusive river Carron prominently at the entrance, the same name which is given to the mortuary. Thus in the deliberate choice to take up the possibility of knowledge about the future death of an individual and to amplify this possibility in an explicit system of purely palliative care, those who establish hospices are making a powerful statement. Death and the reality of human mortality are being placed boldly before the eye.

'Strathcarron', the river valley, can be seen as the organising metaphor through which this particular kind of openness is being created. The valley which leads the individual towards their death, which steers awareness towards the inevitability of mortality, is subsumed within the hands which offer and support. With the powerful gesture of giving prominence to death comes the equally powerful promise of the relief of pain and suffering. Though the hospice has been able to accept all those referred to it within the Central Region, this acceptance is conditional upon the patient being told, in some form, the truth about their diagnosis. Those who seek pain relief become part of a movement towards Strathcarron Hospice, and ultimately towards the Carron Room within. This involves an extended exposure to death. Wards within the building open directly into the entrance area, a large stairwell to the left of the external glass doors. Dying people are thus made immediately visible.

Entry to this space can provoke fear. In seeking pain and symptom control patients confirm their diagnosis. An elderly patient, being helped back through the doors after a brief trip home to her cottage, said, **"I'll never get out of this place"**. A younger couple, in their forties, were brought in for the dying husband to receive counselling, an attempt to help him

cope better with pain. His wife's determined vitality, on show during the journey to the hospice, collapsed visibly on entry to the building. Similarly friends of patients sometimes have difficulty in referring directly to Strathcarron, and the word 'hospital' is used to mask the more unequivocal associations of the word 'hospice'.

In summary the creation of Strathcarron Hospice, a culture of care, within Randolph Hill Mansion, can be seen as a way of bringing death to the fore by placing it at the centre.

Behind this powerful and sometimes fear-provoking gesture lie additional and different sources of power in the resources of narcotic drugs, extensive nursing care and a Christian foundation. Cicely Saunders pioneering research in pharmacology has resulted in the availibility of highly sophisticated drug 'cocktails'. After an initially high prescription, such drugs can control pain through the regular administration of smaller doses which pre-empt its return. Nurse:patient ratios are high[8] and additional care is provided continuously by occupational therapists, Red Cross beauticians, and volunteers who offer patients companionship, outings, and practical help such as letter-writing. In Strathcarron the Chaplain's regular presence underscores a Christian emphasis. Phrases such as:

> **"whether in this life or the next, she is in God's hands"**

form part of his conversations with soon-to-be-bereaved relatives. Often conducted in public spaces within the hospice, such conversations make available a Christian perspective to a nearby listener. It is through the fusion of such resources that an open encounter with death is managed. It is the continuous task of all those associated with or encompassed by Strathcarron.

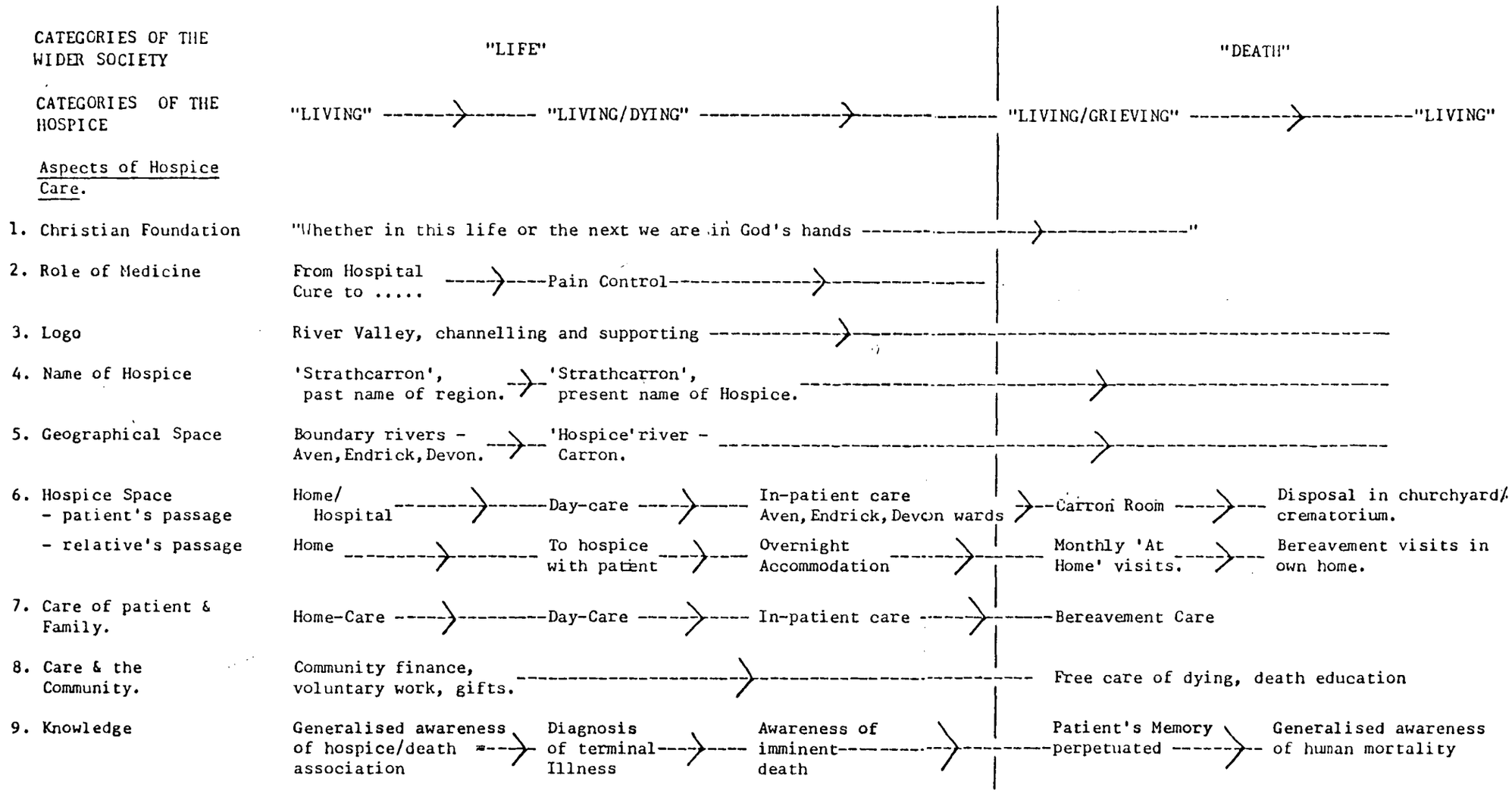

Figure 2: Hospice Care; the temporal, spatial and conceptual breaching of the prevailing life/death boundary.

The diagram shows Hospice care to be a cultural milieu within which the idea and the experience of transition are imaged and expressed on multiple levels.

This section describes the appropriation, and the fusion, of traditional sources of power in the creation of Strathcarron Hospice. It is written in a style which reflects the continuous flow or interchange between one aspect of hospice life and another. In the diagram below each aspect has been separated out - in order to demonstrate the multi-dimensional breaching of a prevailing 'life'/'death' boundary. It is significant that while the role of medicine has been extended into the area of dying, it nonetheless remains limited to the control of bodily experience in life.

4 SUMMARY

This chapter focusses on two examples of places within which dying occurs in Great Britain today. It shows how the nature of each one provides both an inspiration for and an interpretation of the individual's experience. The residential home can be located within the cultural and social context of a post-medieval Western world view where analytic, differentiating models allow a far-reaching control of human experience. Separation and distancing are the strategies through which the painful aspects of the otherwise culturally and socially ambiguous ageing/dying process are transformed into a figurative representation of 'ordinariness', that is to say independent adulthood. Both temporally as well as spatially, both socially and conceptually as well as physically, the home's boundary severs the connections between the process of growth and the process of decline. Framed within this gulf, the bounding of institutional time and space figuratively re-creates the prevailing cultural categories, 'life' and 'death' and systematically imposes them upon an unevenly deteriorating population of elderly people. The centrality of this divisive, figurative boundary has become the focus for the transformative strategies embodied in Hospice care.

Spanning the boundary between life and death the Hospice Movement has created separate spaces within which the experience and the idea of transition is demonstrated and made possible. Thus the boundary between the hospice and the surrounding community is the site of maximal visible movement, a public space where the life/death continuum is powerfully suggested.

From an initial assertion that death is currently managed through a separation of living space and dying space, discussion has now moved to two specific and separate places where death occurs. The residential home frames the final, extended and unpredictable process of ageing. The hospice manages the sudden development of rapidly advancing terminal illnesses. Both address themselves to human experiences which fit uneasily within an ordered relationship between life and death. While the protracted frailty of very elderly people can blur the distinction between life and death, the unpredictable yet inescapable onset of a terminal illness brings the two into frightening proximity. Without doubt a sudden death may bring a profound sense of disorder to close survivors, yet the deceased escapes the cancer sufferer's painful awareness of the rapid approach of their own death.

As shown, the residential home manages the ambiguities of the ageing process through metaphoric strategies which impose a fictively ordered life/death separation upon frail elderly people. Prevailing cultural and social categories are thus re-produced. The hospice exemplifies a set of innovative strategies which not only question but also actively re-structure the categories through which individuals in the West are currently living and dying.

NOTES

1. See Katherine Whitehorn, 'Care or Cure ?', The Observer, January, 1983.

2. See Chapter Two, pages 42-43 and Chapter Four, pages 90-91.

3. See Chapter Three.

4. See Chapter One, pages 30-39.

5. See Chapter One, pages 17-18 and 32.

6. See Chapter One, pages 33-34.

7. See Chapter Three, page 83.

8. There is one nurse to every 2.8 patients at any given time. See Strathcarron Hospice. Annual Report and Accounts for the year ending 31 December, 1981.

CHAPTER SEVEN

STRUCTURING THE PASSAGE FROM LIFE TO DEATH

In exploring contemporary approaches to death which involve the creation of rigid boundaries between the ideas and the events of living and dying, the residential home and the hospice have been examined as contrasting examples of separate spaces within which dying occurs. When compared with the strategies of distancing and separation which constitute the social order of the residential home, the framing of death within the hospice more closely resembles ritual processes throughout the world. As shown, the transformative power generated within each context, whilst oriented towards very different ends, nonetheless reveals the critical role of framing in the creation of a particular quality of experience.

Discussion of the above points is here carried into the related area of bereavement. As will be shown, this death-related process may also be experienced within sets of boundaries which have a powerful bearing upon the relationship between the sense and the reference meanings of events and utterances. Whilst the primary focus of the entire thesis is the biological process of dying, transition as a social and emotional experience does not attach itself in any straightforward manner to the continuum of biological changes. An expanded discussion will focus on the residential home as a bounded context where the biological process of ageing is perceived continuously through all the senses - and where awareness of this process is simultaneously subject to continuous metaphoric manipulation. This raises the area of the associated process of grief, one which is often encountered privately, in the absence of any outwardly perceptible social or material forms. While the Hospice Movement explicitly stimulates a carefully managed experience of anticipatory grief, it is part of a process which continues long after the event of death. Outside the context of the hospice,

bereavement may be experienced as a painful, often paralysing confusion or overlapping of conceptual categories 'life' and 'death'.

1 PASSAGE THROUGH RESIDENTIAL CARE

Perhaps more than any other institution the residential home for elderly people is implicitly oriented towards an extended biological process - in this case ageing. Fieldwork reveals the process to be contained within a social, spatial and temporal loop which lies hidden between admission and exit. As noted a resident's initial entry is managed by the Matron within the public space in and around her office. This is a carpeted corridor with pictures on the walls and a waiting alcove with flowers, a coffee table, magazines and pictures. It is an effective representation of the figurative reality of homely independence which, it will be shown, is used extensively in the masking of the looped passageway through Highfield House.

Having been brought in through the public space of the courtyard the new resident can expect to be allocated a room on the first floor of the building. Thus they will have been taken in and placed in a space which orients them away from this point of contact with the outside world. These rooms face outwards, away from the city and away from the two neighbouring institutions, the Hospital and the County Hall, both important to the life of the home. Literally 'put out to grass' the remaining 'private' space left to the resident overlooks lawns, hedgerows and two roads which lead out into the countryside to the north west of the city. Theirs is an environment of monochrome lino-tiled corridors and identically furnished bedrooms. The peripheral homeliness of the institution does not extend into the residential corridors. Any transformation of the living accommodation into a personal space must be wrought by the resident themself, using the few possessions they have brought in

with them. The bedrooms have no electric power points and the home has no payphone.

While Strathcarron Hospice embodies the idea of continuity and transition, imaged in the river valley which channels and supports, the passage of deteriorating individuals through Highfield House is submerged in an unchanging, depersonalised environment. Only the small bedside rugs, the trinket boxes, the remnants of former dinner services or table linen and the mantlepiece clocks serve as personal reminders - or iconic representations - of entire, lost domestic contexts. Remaining figuratively alive in the memories and the reminiscences of individual residents, the past is embodied in such small inanimate objects. They stand as sad reminders that, just as they have survived the homely spaces where once they were framed, so too they will survive the dwindling physical presence of their individual owners. Past, present and future are thus evoked and brought together in a continuum. These are the symbolic gestures of individuals and not of the institution.

Having been moved from the periphery to the centre, upwards and away from their point of entry, the individual resident is required to conform to the divisions of time and space which have been adopted within the home. Care staff gently direct the new resident from early morning tea in bed, to breakfast, to a seat in one of the lounges, to lunch, and so on. Care staff make their bed, wash and iron their now-labelled clothes and determine where and when they will sit to receive their food. Every aspect of the resident's environment is shaped by care staff.

For as long as an elderly person is capable of meeting the requirements of the category 'resident', they will remain at the centre of the institution. Framed within institutional time and space their individuality, as embodiments of human deterioration and decline, is submerged within a depersonalising category. Any physical or mental deterioration, however, may lead to the

beginning of a movement back towards the periphery, and out of this category. Those who become incontinent, unable to walk without support or perceptibly 'confused in their minds' will find themselves moved downstairs to what staff refer to as the 'frail' corridor. In their use of the term 'frail', staff hint more openly at the loop or passageway which is threaded through the otherwise intractably rigid time and space of the home. Thus residents' everyday comings and goings, back and forth between bedroom, bathroom, lounge and dining-room, are in reality a one way movement through non-ordinary space, its name referring directly to their own death-evoking physical and mental conditions. Should staff fail to attend to the home's implicit task - of channelling deteriorating elderly people towards their deaths - then the carefully submerged disorder of ageing bodies might rapidly emerge to make visible and explicit the true nature of the institution.

Residents from the 'frail' corridor may also find they are no longer accepted in the lounges where fitter residents pass their days. Care staff will seat them in the alcove nearest the dining-room and it is here that once again they become prominent, visible and singled out for attention as an individual rather than as a member of a category. Becoming more nearly the corpses which are the home's unspoken product, they are recognised swiftly as the staff's primary focus. Not only staff but also the more healthy and mobile residents recognise an emergence of the literal movement towards death. It is rare to see one of the more healthy and mobile residents sitting in the very accessible and convenient alcove area.

Similarly in the dining-room 'frail' residents are moved forwards, closer to the hatchway into the kitchen. Referred to as 'the little people' - who receive smaller meals - it is this group who will be addresssed by Christian name only and will tend to be given nicknames. As confusion and an increasing lack of bodily control erode all but the last vestiges of an elderly

person's individuality, a fictive persona is predicated upon them. Roleless and physically incapable, their attributes are inverted in nicknames such as 'King Arthur', 'Queen Gertrude', 'the Ballerina' (a squat, totally immobile woman), and 'the Two Musketeers' (two women, one very unsteady, one very poor-sighted, who arm-in-arm steered each other slowly through the home). Through such nicknaming a grim literal reality is both acknowledged and humourously diffused. It is the names, or nicknames, of these residents which will be listed and underscored in the report book where care staff record the events of one shift for the benefit of those taking over. The phrase:

'Remaining residents no change at the time of report'

is written beneath the list of individual names and encompasses all those whose slow ageing still remains submerged within the institutional category, 'resident'. A fictive sense of stability or permanence is thus imposed upon a gradually fading population. The 'little people' however are beginning to move away from the centre, a movement which in time will lead them back to the periphery. From their prominent position in the alcove it is this group who are most exposed to the passage of a corpse from sickbay along to the morgue. Similarly it is to these individuals that the clothes of the dead will be given, sometimes within a day or two of the funeral.

As their physical deterioration increases and illness sets in, these individuals will be cared for in one of the two sick bays on the 'frail' corridor. As they move visibly closer to the literal reality of dying their previously ambiguous status, betwixt and between the categories 'life' and 'death', is finally left behind. No longer subject to the required uses of time and space, the very poorly individual will receive frequent attention from the Matron, the only member of staff with medical experience - and in addition from outside doctors. It is the Matron who

often sits with them as they are dying and, after death, it is she who will lay out their body. It will be wheeled out along the entrance corridor and into the morgue which lies beneath the Matron's flat, once again at the periphery of the home. The body passes back into the outside world through the morgue doors into the courtyard, the Matron guiding the coffin into the hands of the undertaker.

As shown,[1] the courtyard which bounds the time and space of ageing and dying is critical to the structuring of that passage. It is the Matron's position at this peripheral point which empowers her in a central transforming role. Whilst the continuum of life and death is charted in the visible passage of individuals through this building, she nonetheless promotes an illusion of 'life' as a stable and enduring state, to which the would-be resident may aspire.

I have selected four figurative representations of the 'homely here-and-now' of Highfield House which the Matron helps to promote. Each one reveals the strategy of metaphoric transformation which masks institutional processes pragmatically addressed to the management of bodily deterioration. They are:

(1) a Guide Book given to prospective residents and any family they may have.[2]

(2) the Name of the Home.

(3) a Valentine's Card sent to residents by volunteer helpers, the Friends of Highfield House.

(4) an Open Day, or summer fete, to which all associated with the home are invited.

Whether written down or performed, these four representations can be seen as texts amenable to hermeneutic analysis (see Ricoeur 1981:152-164), and illustrative of the transformative strategies already discussed. Each one has a highly 'readable' sense meaning which is oriented towards the resident or relative and re-assures them that entry to Highfield House is entry to a favourable life in 'care'. The perspective of such a 'reader' can be seen to lie within the internal sphere of the text's meaning. As will be shown, each text has additional, largely implicit, referential meanings. Once set within the cultural context of the wider society and of residents' lost past lives, present dependencies, and pending future death, those otherwise implicit referential meanings can be read out. A hermeneutic analysis becomes possible once the material is contextualised in this way.

1.1 Guide for Prospective Residents.

Local social services offer a guide to elderly people contemplating admission to Highfield House. On the first page, in 'A message to you from the Director of Social Services', there is an acknowledgement that:

> ...many people are apprehensive about applying for a place in a home.

Though the language of the guide is gentle and circumspect in style, its content advises the would-be resident that tenancy or ownership of their home must be given up; that their furniture cannot be accommodated; that the officer-in-charge will take possession of their money, valuables, pension book and medicines; that the times and places for receiving visitors are circumscribed; that the use of alcohol and tobacco must be moderated. In the context of a residential home for very elderly people this shedding of possessions, responsibilities and personal space readily takes on one particular set of meanings - that death is the impending reality. Indeed those who continue to live alone in extreme old age often fear the spectre of

outsiders intruding upon personal space such as cupboards and drawers after their death.

Offered prior to admission, the guide book can be seen as an intervention in the passages from sense to reference, from a house move to an anticipatory acknowledgement of death. It is at this point, at the periphery, endorsed by the Director of Social Services, that attempts are being made to transform the otherwise frightening referential meaning of a residential system of domestic and nursing services.

Thus the guide book acknowledges the possible apprehension of its readers, being offered in the hope that:

> ...it will serve to allay some of the worries you may have.

In accordance with this hope, it seeks to soften its stipulations in subtly persuasive language such as:

> ...you will be encouraged to...
>
> ...you are expected to...
>
> ...it is common practise for...
>
> ...in the interests of your safety...
>
> ...you are strongly advised...
>
> ...you are asked to remember that...

It represents the home as:

> ...well furnished, everything possible having been done to make it as homely and comfortable as possible...varied and interesting menus are provided...a range of activities are arranged within the home which may include concerts, socials, table games and a library service.

In resonant language such as this the outsider's perception of the institution as some kind of last resort where the waiting game begins, is metaphorically transformed in a figurative representation which stresses material comfort and enjoyable sociality.

1.2 The Name of the Home.

In the naming of the residential home a similar metaphoric transformation is introduced in order to mask its less welcome implications. Despite the fact that the word 'home' implies something more than just a house, the prefacing of the word 'home' with the name of a category, 'old folks' or 'dogs', rather than an individual, 'Mr Wilkinson', immediately inverts the more positive meaning of the word. Notions of hearth and home sweet home, of the private and the domestic, then give way to images of a public, rule-bound space into which the individual is 'put away'. Thus, although Highfield House is described as being 'as homely and comfortable as possible', the stigmatised word 'home' is not used to name it. Instead a name becomes a title in the substitution of the word 'house' for 'home'. For example, where institutions have been established in rather grand properties, formerly owned by wealthy families, the legacy of titles such as 'Metcalfe House' or 'Grosvenor House' is pressed into service, thereby masking the institutional with something of the dignified and the stately. This practice is extended in the naming of modern, purpose-built homes such as Highfield House and indeed staff refer to an overcrowded institution as a 'heavy house'. The word 'home' is used to name only one of the forty-one institutions for elderly people in this region of the North East. Preferred are titles such as 'Palatine House', 'Gladstone Hall', 'Greenfields House', 'Bydale Lodge', 'Grove Park', 'The Lawns' and 'Moorcroft'. Overall it is the title 'house' which predominates, being used to name twenty-nine of the forty-one homes in the region.

In the rigorous exclusion and inversion of the word 'home' and its associations with category rather than individuality, the cultural manipulation of awareness is exemplified. Rather than being 'put away into an old folks' home' or 'admitted to care', the elderly person 'becomes a resident in Metcalfe House'. Through the use of this particular cultural linguistic device dependency and impending death are metaphorically transformed and rendered less perceptible to those confronted with admission to an institution.

This practise stands in sharp contrast with the strategy of the Hospice Movement. Like residential homes, many hospices are established in existing properties - e.g. Randolph Hill Mansion, Denny and Challenger Lodge, Edinburgh. Rather than appropriating existing titles, hospice committees often adopt the names of saints or the earlier names of their immediate geographical location - e.g. 'Strathcarron' is the seventeenth century name of the region within which the hospice is set.

The describing and the naming of the residential home are two areas amenable to transformative interventions. In addition a figurative representation of the home is also given literal form in events or performances which take place at the periphery of the home. These events arise from the efforts of the Matron in conjunction with outside helpers or volunteers. The two I will describe are the sending of a Valentine's card to the residents, and the Open Day. A group of people known as the Friends of Highfield House are responsible for both.

1.3 The Valentine's Card.

The Friends of Highfield House are a group of about eight or ten middle-aged women and men whose regular involvement with residents is largely confined to the organisation of a weekly bingo session. Their role in creating a figurative representation of residents is however more far reaching. Using

the occasion of St Valentine's Day and its associations with the offering of romantic love between individuals, the Friends addressed a poem to all those encompassed by the institutional category 'resident'. After some initial difficulty a Valentine's card which contained no implicit or explicit sexual reference was bought. A verse was typed on the back of the card which was then pinned on a notice-board outside the dining-room in such a way that the card's printed message for the individual was obscured. It read as follows:

> We love to be among you
> To share in all you do
> The residents of this home are dear to us, 'tis true.
> So upon this special day
> We are pleased to write these lines
> To the friends of Highfield House - you <u>all</u> are Valentines

In these lines the referential meanings associated with an institutional category, 'resident', are entirely supplanted by figurative meanings associated with Valentine's Day. Those to whom it is addressed are very old people who have little option but to live among others who are similarly categorised by their age and their degree of dependency. To 'love', to 'share in', to be 'dear to', to experience a 'special day' and, indeed, to be 'a Valentine' are the experiences of individuals involved in or open to the possibility of romantic love. The senders of the card have appropriated an expressive form from this area of life in order to address those socially categorised as unavailable for romantic love and who live with and are cared for by those with whom they have no longstanding ties of blood or affection. Only dependency and age have brought them together.

Thus the senders of the card are addressing a category, 'you <u>all</u> are Valentines', in such a way as to transform its implications through an evocation of the 'special' individualizing experience of romantic love. So flimsy is the illusion, that cards with any sexual content were dismissed by the Friends, lest reference to a more literal expression of romantic love should draw attention to

the literal reality of ageing bodies, culturally perceived to be unsuitable for lovemaking. In such a context, helpers' sensitivity to language or images of this kind is clearly heightened.

1.4 The Open Day.

This is an annual occasion when outsiders come into the home and its grounds to buy products such as the plants which residents have propagated. When I attended I found that the residents themselves were largely conspicuous by their absence from this event. A few fitter individuals manned stalls and a selection of the infirm were lined up, blanketed in wheelchairs, with one care assistant per chair to attend to them. However the majority of residents could only be glimpsed as they watched the event from upstairs windows. The jazz band, the fortune teller, the rummage stalls and the teas served by staff and Friends successfully predominated. The ostensive purpose of the event is fund-raising, money being used to buy a third television set for the home. However the vitality and sociality of the tea shop and the fairground, in briefly supplanting an everyday atmosphere of boredom, isolation and weariness, offered an effective literal representation of the guide book's figurative description - i.e. of a homely, comfortable environment where varied and interesting menus, concerts, socials and table games are provided.

As a summer-time occasion, the Open Day is staged almost entirely outside or on the periphery of the home. While teas were served in the dining-hall the majority of space within the home, the bed-sitting rooms, sickbays and corridors, is effectively not 'open' to outsiders. Diverted from any confrontation with the literal reality of ageing in residential care, outsiders encounter only glimpses of the life of a resident. Both are figurative. One is the small group of elderly people who, briefly, are given control over a stall; the other is the row of frail residents who, briefly, are taken outside the building and are seen each to receive the undivided attention of one care

assistant.

Lakoff and Johnson argue that:

> ...people in power get to impose their metaphors. (1980:157)

In the hierarchical ordering of residential care, metaphors such as names and descriptions, projected by powerful members of Social Services Departments are taken up and given literal form by the heads of institutions under their authority. Scripts assembled by the middle-aged at a distance from the literal reality of ageing are given material form in performances promoted by the Matron at the periphery of the home. Outsiders may thus be reassured. Of more central importance is the exposure of care staff and residents to periodic special events which tangibly reveal the metaphors through which care is continuously being made acceptable.

The Matron also demonstrates this figurative re-description inside the home on occasions such as meal-times and birthdays. When the Matron herself serves the main meat course at lunch-time she performs the task slowly, carefully choosing the slice of ham appropriate for each individual resident. This is in marked contrast with the normally rapid spooning out of food by the kitchen staff. Similarly at residents' birthday breakfasts when a carnation buttonhole is presented to them, the Matron seats herself at their table, sharing in the opening of their cards and chatting in an extended and leisurely fashion. Again this contrasts strongly with staff's swift expressions of humour or affection as they sweep the dining-room floor around her. Figurative 'care' is thus performed before residents and staff, both of whom are involved more literally in the management of dependency.

In summary the example of the residential home shows the biological processes of ageing and dying being managed in culturally created isolation from any overt social or emotional experience of transition. Given the confined, condensed nature of such an institution it is an example which richly illustrates the strategies of distancing and separation, less obvious but nonetheless powerfully pervasive, within the wider society.

2 DISORIENTATION THROUGH BEREAVEMENT

In the associated area of bereavement lie further examples of how awareness can similarly, and perhaps more emphatically be deflected from the life cycle changes which are its source. Exploring the practise of double obsequies through which process and change are demonstrated in more traditional societies, Hertz makes the following statement:

> The brute fact of physical death is not enough to consummate death in people's minds: the image of the recently deceased is still part of the system of things of this world, and looses itself from them only gradually by a series of internal partings. We cannot bring ourselves to consider the deceased as dead straight away: he is too much part of our substance, we have put too much of ourselves into him, and participation in the same social life creates ties which are not to be severed in one day. The 'factual evidence' is assailed by a contrary flood of memories and images, of desires and hopes. The evidence imposes itself only gradually and it not until the end of this prolonged conflict that we give in and believe in the separation as something real. (orig.1907; 1960:81-82)

Like ageing in residential care, bereavement, as commonly encountered in the West, can be seen as a deviation from experiences and practises which elsewhere and at other times allow the 'brute fact of physical death' to be slowly 'consummated in people's minds'. Examples of the metaphoric

manipulation of the quality of experience in Highfield House revealed the lack of any ritual 'demonstration' of the process of ageing and dying. Indeed these biological processes were disguised or hidden. With respect to bereavement it again becomes fruitful to take up the broader conceptual themes introduced earlier in the thesis in order to show how the 'factual evidence' of a death is similarly distanced or muted.

In the following discussion I will explore Western concepts of time and of the self, showing their relevance to key areas such as the medicalization/professionalization of death and the concept of privacy. Rather than the symbolic mastery embodied in a single role such as the home's Matron, what emerges is a broad combination of more diffuse circumstances which nonetheless can effectively isolate the bereaved person from both the literal reality of death and also from their surrounding social environment.

Thus, for example, Burridge's notion of a Western self emerging out of a generalised individuality (1979:32-52), can shed light upon the process of bereavement. Similarly relevant is the Western concept of 'growth', which is perceived as a stable, linear process of accumulation and is reflected in the experience of time and its passage. Set alongside an introductory discussion of how the nature of time, and of the self, contribute towards the Western experience of disorientation at the time of bereavement, is an exploration of contemporary iniatives oriented towards the re-creation of the grieving process. Discussion of the links between the development of bereavement counselling and the growth of Hospice care offer a final contrast to the previous example of the hidden passage through Highfield House.

2.1 Time

Whilst the cultural concept of time as a linear, unrepeatable sequence predominates within the West, the finite nature of temporal bodily existence is not made evident. The expectation

of a long life is well established and terms of reference such as 'premature', 'tragic', 'untimely' or 'wasteful' are often used to describe deaths which occur before individuals have reached their seventies. Within a relatively extended lifespan such as this the linear passage of time can assume an apparently endless, cyclic nature as the calendar continues to repeat its sequence of months, days of the week, birthdays and anniversaries. Death can often be the one event which brings into focus the finite, unrepeatable nature of the time sequence which frames human life. The resulting disorientation is often experienced as a sense of timelessness. Stephen Verney, Canon of Windsor, describing the death of his wife, relates his 'discovery' on that occasion of the constructed nature of time. He writes:

> Generally, we are so busy keeping our engagements according to clock time that we exclude this awareness of timelessness, but when somebody you love has died, the barrier between these two worlds grows very thin, and a new pattern of events is set free to happen around us. As a friend, Raymond Panikkar, said to me : 'The time of death is the death of time'. (1977:273-274)

In a poem Susan Wallbank similarly alludes to a sudden awareness, when death takes place, of the illusory nature of time perceived as an endlessly repeating cycle:

> Death makes philosphers of us all
> the prospect of it in reality
> disturbs time itself
> lifelong patterns fall from us
> as withered leaves lay bare the trees
> in winter
> and did we really yesterday believe
> in mortgages and birthdays
> in home and holidays next year
> in such blind innocence.
> Philosophers are mad
> or must become so
> when face to face

with such great sadness.
(1984:12)

A bereavement can therefore be a focal point where the prevailing concept of life as a state of enduring adulthood is brought up sharply against the literal reality of loss and change. The sudden death of a child, a young adult, or lifelong friends in old age, can bring short-term perspectives of time, that is the repeatedly confirmed expectation that the individual will awaken to the same world that was left behind the night before, sharply into conflict with the less apparent or tangible concept of human life as a dynamic enterprise. Human life imaged through the sparrow flying in through a hole at one end of the barn roof and out through a hole in the other impinges little on short-term perspectives of time. Only when the individual disengages from the daily rhythms by which time is perceived can they become aware of indisputable yet non apparent facts such as that members of such social categories as 'the elderly' or 'the infirm' will almost certainly be dead and lost within the next five or ten years. The jolt of bereavement can be seen as the experience of the chance simultaneity of the varied rhythms by which time is perceived. The compelling regularity of the rhythm of the passage of days easily obscures the deeper, underlying rhythms of the passage of generations.

Hence the immediate, shocked amazement expressed by an elderly lady, recently widowed, when describing the event of her husband's death for the first time:

> **"He was gone. How could it have happened like that ? I had only turned my back to get his shaving stuff and that was the moment he went."**

The daily shave and the unique moment of death compete for the same instant in one woman's life. She is suddenly exposed to the simultaneous motion of vastly different kinds of rhythms in her life.

Such dissonance is deeply intrinsic to the experience of bereavement. Moreover, the experience is not confined merely to the immediately bereft and grief-stricken; it spreads and is felt in new and varied forms among all the various networks within which the dead person was imbedded. At this point the expected continuity and sameness of time which obscures the inevitability of death is called into question - such statements as **"I can't go on living without him"**, **"Time suddenly stood still"**, jostle with the statements **"Life must go on"** and **"Time heals"**. The ending of all the biological rhythms within one body, most notably the heartbeat, is mirrored in the dislocation of some of the most basic daily rhythms in the lives of bereaved people. The immediate bodily agitation of grief is enacted within the context of wildly disordered patterns of eating, sleeping and moving about within the neighbourhood. In death the slower, deeper motion of the passage of generations has a sudden supremacy for bereaved people.

In rituals such as the Jewish shiva this kind of changed awareness once death is encountered is culturally affirmed and made explicit. Here the bereaved family spend up to a week confined to the home of the deceased after the funeral. Washing, shaving and the changing of clothes is forbidden. Seated on low stools the family spend their times in prayer and in receiving visits from friends and relations. Conversation focusses on the life of the deceased relative. In this way all the common measures of the passage of days are removed.

In many non-Western cultures practices such as this make awareness of less apparent dimensions of time accessible. Fasting, prohibitions on movement and on washing of the body, the out-of-the ordinary movements involved in dance and in travelling all serve to dislocate daily rhythms and allow the perception of possibly slower and less predictable rhythms.

2.2 The Self.

Like time which is thought of as a linear sequence and experienced as an endless cyclic process, the notion of the self as a fixed enduring entity is absorbed and affirmed through repeated interraction with a particular external environment. Continuity lies at the heart of a Western sense of self. Awakening to an altered self, a self with a high temperature or a hangover, the individual is confronted with their image of the self as it ought to be. The expectation of stability is assaulted by the possiblity of change.

In his essay on death Hertz suggests that in many traditional societies it is not only the dead but also the bereaved who are ejected from a familiar world (orig.1907; 1960). Most graphically it can be said that, in the West, at the burial of a close relative or friend it is not only the deceased who is buried but also a part of the survivor. Just as a change in state of health, place of work or home, or physical appearance can throw the internalised picture of the self into relief, so the loss of a close friend or relative may challenge prevailing Western notions of the self - in this case as a stable and independent entity. In our society close relationships are important, often determining constitutents of the self as it is experienced. In particular the loss of a partner or a child may represent a loss of self. Grieving and the process of bereavement is therefore, implicitly, the process of re-creating or reinterpreting the self.

Since the idea that the loss of a partner entails a loss of the self is at odds with an over-riding cultural emphasis on personal continuity, any awareness that the individual may in some sense be 'merely' a part of a larger whole and therefore vulnerable to external changes receives little external cultural reinforcement. In such a setting the cognitive processes through which the self may be re-created are, perhaps unsurprisingly, given little

external expression in cultural or social forms. It is this relatively uncharted area which has become a focus for medical, psychiatric and academic study in the West.

Dora Black, a consultant psychiatrist working within our own society, describes grief as predominantly a healthy form of depression.[3] Numbness followed by a violent physical and emotional surge of protest often marks the onset of grief but a period of withdrawal into depression is, she feels, the process through which the re-creation of the self is accomplished in our society.

She describes the process in the following terms. In depression the individual withdraws from outside contact, and loses touch with customary daily habits or rhythms of eating and sleeping, becoming absorbed in obsessive, repetitive thoughts. Through behaviour of this kind the past self may be examined repeatedly. The reliving and the summing up of both pleasant and regretted aspects of the self allows for the relinquishing of that self. Its more elusive and ambiguous aspects, as defined by the lost relationship, may not easily be relived and therefore relinquished. Nonetheless, the compulsive and repetitive mode of thought, which my own informants repeatedly described, is not only characteristic of depression but also instrumental in affirming and re-affirming the reality of change in the face of deeply imbedded cognitive models of stability. It becomes evident at this point that attempts, either by bereaved individuals or their helpers, to maintain superficial daily rhythms in an artificially dominant position may exclude and hinder the bereaved person's involvement with the deeper processes of change which are occuring. A de-structuring of external reality is necessary for the internal re-structuring of the emergent future self.

The theme of repetition as an instrumental albeit depressive mode of thought has wide implications for the process of change. Change as a 'fact' has little meaning in the face of the experience of stability. It is only when repeated experiences of change establish a stable yet changed state that the 'fact' can be assimilated and come to have significance. Repetition is a means of learning, not only in childhood, but throughout adulthood. This becomes particularly evident in situations of sudden and far-reaching change. Informants talked of their repeated intentions to share some event or item with a partner who is no longer there, in one case of constantly dialling the phone number of a mother who had been dead for a week or so. C.S. Lewis in a diary record of his thoughts following the death of his wife, uses two images to communicate this point:

> Thought after thought, feeling after feeling, action after action had H. for their object. Now their target is gone. I keep on through habit fitting an arrow to the string; then I remember and have to lay the bow down. So many roads lead thought to H. I set out on one of them. But now there's an impassable frontier-post across it. So many roads once; now so many culs de sac. (1961:39)

This kind of involuntary reinforcement of the reality of a change may go hand in hand with the need to talk constantly about the past, about the events surrounding the death and about the sense of loss. Seabrook describes this need in a collection of interviews with people who have become socially isolated:

> The two women put questions to each other to elicit facts that both are thoroughly familiar with. It is like a fixed scenario. The details surrounding the event are recounted with great circumstantial intention, and trivialities take on a momentous importance; no Wednesday, no Saturday could ever be quite the same again, saturated as they are with the panic and shock of the accident that killed her husband. In their reconstruction of the past, the old use an almost incantatory repetitiousness; a feeling that if they do not

> alter a single feature of such a painful experience the true explanation and significance of it may reveal itself to them. (1973:87)

By the same token the repetition of events as well as words can stimulate the pain involved in 'coming to grief'. For example when I visited an elderly lady who had been a widow for four months I mistakenly assumed she had been warned of my visit. My opening announcement as to why I had come provoked floods of tears. The first words she managed described her distress that so many of her acquaintances in town were unaware of her husband's death. Her shopping trips invariably involved a meeting with such an acquaintance - and yet another announcement of his death. My knocking on her door to talk about death, rather than read the gas meter, was another re-affirmation of his death and significantly my arrival immediately brought to mind the painfulness of all the other repetitions of that most unwelcome fact which she was being forced to experience. Each repetition consolidated the reality of her present situation.

In summary, Western concepts of time and of the self together give rise to a cultural concept of the self as an integrated, coherent entity which endures largely intact over time. The feelings and the responses which bereaved people describe can be seen as a sudden, painful confrontation with the figurative nature of such a concept. Process, the movement from life to death, from the category 'married' to the category 'widowed' is obscured through the same illusory sense of stability which is brought to bear within the residential home. It is to this problematic area that those working within the death-awareness movement have addressed themselves.

2.3 The Re-creation of Process.

The work of Murray Parkes, produced within the Western 'death awareness' framework stresses the processual nature of bereavement (1972). Kubler Ross posits a similar series of emotional stages experienced by the patient diagnosed as

terminally ill (1970). Over a period of at least a year the individual bereaved of a very close relative or friend can expect, in Murray Parkes' view, to experience by turn - a sense of numbness, of panic, of restless searching for the deceased, a tendency either to sense the presence of the deceased or to avoid reminders of them, and strong feelings of anger and guilt. The first anniversary of the death may mark an upswing in mood but the relinquishing of intense emotional involvement with the deceased may not occur until well into the second year of bereavement when movement towards a new, independent identity may be detected.

One of the most significant points made by Murray Parkes concerns the nature of the emotional experience 'grief'. He describes it not as depression but, rather, as 'acute and episodic pangs', 'episode(s) of severe anxiety and psychological pain' (1972:57). Whilst the frequency of pangs is greatest during the early weeks and months of bereavement, chance reminders of the deceased can stimulate occasional, intensely felt pangs even a year or more after the death. This model of grief is expressed succinctly in Elizabeth Jennings poem:

> Time does not heal
> It makes a half-stitched scar
> That can be broken and you feel
> Grief as total as in its first hour.
> (1984:29)

While Black discusses grief in terms of depression rather than pangs, her emphasis on periods of withdrawal and repetitive thought is in some senses an echo of Murray Parkes' model.

As I will go on to argue, bereavement, undoubtedly an extended emotional process in the West, can perhaps best be understood in terms of a disorientation or dislocation of the individual in relation to the world around them. The episodic pangs and repetitive thoughts identified by Murray Parkes and Black can be understood in terms of a series of conceptual shifts between the

two conflicting sets of meaning through which the bereaved individual interprets their own experience. In both the hospice and the residential home for elderly people the relationship between the conceptual categories 'life' and 'death' is at issue. The rigid, culturally-defined boundary through which the two categories are opposed raises difficulties in both social contexts.

Thus the staff of the residential home manage the slow, ambiguous process of ageing by rigidly subsuming it to the divisive cultural categories 'life' and 'death'. By contrast the Hospice Movement seeks to transcend and expand upon that boundary, openly disclosing the category of experience, 'dying'. When a sudden death occurs the conceptual categories 'life' and 'death' can be seen, again, to intrude upon one another, in this case within the experience of the bereaved person. Whilst the same holds true even for long-anticipated deaths, sudden heart-attacks or accidents draw the now figurative category of experience 'life', as formerly experienced by the bereaved person together with the deceased person, closely into conjunction with the literal category of experience 'death', as now experienced by the bereaved person in isolation from the deceased person.

Again Ricoeur's model, drawn from linguistics, of the sense and the referential meanings of action/object/utterance read as text is useful here (1981:152-164). Field material from interviews shows bereaved people describing two rather different kinds of experience following a sudden death. For example:

> **"I know it sounds silly but I can't help imagining he'll be putting his head round the door again this evening after work"**

and

"I feel so wretched inside. I just can't believe that the rest of the world is carrying on with life as if nothing has happened"

In both cases, albeit in rather different ways, the relationship between sense and reference is dislocated. In the first example a figurative sense meaning drawn from an irretrievably lost past continues to assert itself despite the lack of any corresponding reference in the external world. In the second example, a literal sense meaning of such intensity has been assumed that the frustrated sufferer fruitlessly seeks to predicate her own sense meaning as the (inappropriate) reference of all that she sees taking place in the world around her. What is most significant is that one individual will report both of these experiences, indicating that the figurative 'life' of the past persists, and goes hand in hand with the literal 'death' of the present. Repetition or episodic pangs can therefore be seen as the disorienting movement back and forth between figurative and literal realities. The process of bereavement can be understood as the process of first encountering and finally making a temporal separation between the temporarily fused or confused categories of experience, 'life' and 'death'. Their initial, disorienting overlapping can, in time, give way to a relinquishing of 'death' to the past and an appropriation of a present 'life' in the absence of the dead person.

In the West the fusion or confusion within the bereaved individual of figurative 'life' and literal 'death' and, paradoxically, their puzzlement and hurt that literal 'death' may not be assumed as the reference of all thought and action within the world is deepened and extended by boundaries lying between that individual and the world around them. In the same way that the boundary or gulf between the residential home for elderly people and the surrounding world makes possible the manipulation of the sense meaning of the home, so the possibility of barriers between the bereaved individual and the surrounding world allows for the intermittent retention of a figurative sense meaning

('life') long after the literal event of death.

Three areas of contemporary experience in this country can be shown to be critical to the creation and maintenance of boundaries between bereaved people and their surrounding social environment. Brought together they exert powerful influences upon the quality of experience.

2.3 (a) Historical Perspectives. In the autobiographical introduction to his survey of the management of death in modern Britain, Gorer describes 'the full panoply of widow's weeds and unrelieved black' worn by his mother, bereaved of his father in the sinking of the Lusitania in 1915. At that point war widows in similar mourning dress became increasingly visible in the streets. Public mourning of this kind was soon to become the exception for the first time - but only towards the end of the war. Gorer writes:

> One can see the point, of course. The holocausts of young men had created such an army of widows; it was no longer socially realistic for them all to act as though their emotional and sexual life were over for good, which was the underlying message of the ritual mourning. And with the underlying message, the ritual too went into discard. There was too, almost certainly, a question of public morale; one should not show the face of grief to the boys home on leave from the trenches. (1965:6)

The central theme of Gorer's work is that in the suceeding years of the twentieth century bereavement received increasingly little public expression, becoming an evermore carefully hidden and private experience. The social historian, Cannadine offers an alternative perspective on the years following the mass bereavements of World War One (1981). He argues that the very visible elaboration of mourning during the nineteenth century had already been questioned during the last years of that century. The celebration of death which prevailed up until the 1880's

began to wane, giving way to the glorification of death in active (military) service for one's country. In response to the bereavements ensuing from World War One the 'celebratory' ostentation of the nineteenth century was no longer found to be an appropriate form. Describing this period, Cannadine writes:

> Two responses in particular merit attention: the one official, public and ceremonial; the other private, spontaneous and individualistic. The first was the construction throughout the country of war memorials, and the gradual evolution of the ritual of Armistice Day. The second was the massive proliferation of interest in spiritualism. (1981:219)

Both responses, he argues, were widespread and spontaneous - external social forms popularly appropriated for the expression individual emotion. Cannadine sums up his discussion of this period as follows:

> In private seance, as in public ceremony, inter-war Britain was obsessed with death. The easy transition, so often depicted, from a death-dominated, sex-denying nineteenth century to a death-denying, sex-dominated twentieth century completely ignores this massive, all-pervasive pall of death which hung over Britain in the years between 1914 and 1939, and also the inventiveness with which the grief-stricken responded to their bereavement. (1981:230)

After the second world war such rituals lost something of their intensity - e.g. Remembrance Day was held on a Sunday when public immobilisation was less visible, and war memorials erected after World War One were pressed into further service to bear the additional names of those who died in World War Two. In Cannadine's view the management of death since World War Two is not necessarily 'worse' than at previous times during history. The perception of nineteenth century death ritual as therapeutically superior is, he feels, not only misplaced but also misleading in that resolutions to contemporary evils such as

the threatened Nuclear Holocaust, the deprivations of the geriatric ward and the possibility of euthanasia, must be sought from within contemporary practice.

Cannadine's work has been taken up by Richardson who has looked again at the lack of public expression of grief since World War Two.[4] In her view the pall of death which prevailed during the childhood and young adulthood of today's 'young' elderly people (fifty, sixty and seventy year olds) has lead to a current reluctance within this generation to dwell extensively upon the emotional experience of bereavement. It is their immediate successors, the post-war 'boom' generation of the 1940's, brought up to withhold or contain expressiveness of this kind, who have questioned and in part overcome such hesitancy.

In summary the role of two world wars, though variously viewed in terms of their implications, is nevertheless critical in any appraisal of the experience of bereavement today.

2.3 (b) <u>The Professionalizing of the Management of Death.</u>

Earlier[5] it was shown that the categories 'life', 'death' and 'health' are currently perceived and experienced through a medical model. The defining and the control of the transition between these categories by members of a separate social class of professional experts has been the focus of work such as Illich's (1975). Their appropriation of the passage from life to death intrudes, to some degree, upon the emotional, social and practical relationship existing between the patient and their close relations and friends. In the mid nineteenth century emotional death-bed farewells were given extended expression in the immobilising of entire households through the symbolism of black. Such practices lent to the bereaved and soon-to-be-bereaved individual a clearly defined social role vis-a-vis both their dying and then deceased relative and also the outside world within which they found themselves. By contrast the 'loving lie', the protective strategy of the twentieth century cited by

Aries (1981:559-601), may diffuse emotional closeness between the dying individual and their family. Similarly lack of medical expertise on the part of family precludes ultimate responsibility for the management of the death falling to either the patient themselves or to their relatives.

Distances of this kind, established during the period leading up to a death, are extended in the appropriation of the corpse by a member of yet another social category of professional expert, the funeral director. Former practices such as the preparation of the body for burial by a familiar member of the neighbourhood and the subsequent care of the prepared body, in the home, by the family are no longer assumed within much of Western society.

Unfamiliarity not only with funerary ritual but, indeed, with religious ritual in general may further blunt or confuse the senses of a surviving relative whose 'management' of their bereavement has so far consisted largely in the establishing and maintenance of social distance. Whilst these possibilities prevail to very varying degrees within Western society, they can be seen, at whatever level they exist, to help seal off the bereaved person from their social and their physical environment. This raises the final issue to be discussed - the nature of social relationships within British society as expressed at the time of a death.

2.3 (c) <u>'Privacy'; The Control of Social Space.</u> Describing 'the death of the other' during the nineteenth century, Aries mentions the concept of privacy as being central to the confining of affectivity within the nuclear family. He asserts:

> Privacy is distinguished both from individualism and from the sense of community, and expresses a mode of relating to others that is quite specific and original. (1981:609-610)

The concept Aries is concerned to elucidate is, he feels, best described by the English word 'privacy' - from the latin 'privare' meaning to deprive.

In exploring the (medical) management of death in American culture, Sudnow offers a description of the social behaviour if newly-bereaved individuals in his own society. Using Goffman's term, he suggests that they are 'open persons' receiving both close relatives and distant acquaintances into their home without prior invitation. Thus he writes:

> It is apparently a custom in sectors of our society for the immediately bereaved's house to be open in the days immediately following a death...the door is left open and all comers are free to walk in and pay their respects. One finds, in such circumstances, an admixture of close relatives, close friends, and mere acquaintances. (1967:156-157)

Literary sources support the perspective that by contrast with such 'openness' many social relationships in Great Britain are managed according to the rigid and rigorously implicit set of boundaries referred to as 'privacy'. John Fowles, in the character of Daniel Martin, describes an Englishman's reintroduction to privacy on a train journey, one part of a trip back to his former home after living in California.

> Being forced to share a confined space with people to whom you have not been introduced was an activity dense with risk; one might be held to ransom and forced to give some item of information about oneself. Perhaps it was just a matter of accent; a terror of revealing, in even the smallest phrase, one's class, or some dissonance between voice and clothes, opinion and vowel-sound...I had analysed this fear of exposure, this onanistic fondling of privacy, long before...of course it was nothing, in that train; simply six middle-class people wanting to be left alone. But its private transference to a personal world, its murderous use as a killer of

> tolerance and trust, as agapicide, had
> principally ruined my marriage.
> (1977:143-144)

With respect to social relationships between bereaved and non-bereaved individuals, an implicit sense of privacy is often transformed into what may appear to the bereaved person to be a deliberate avoidance. In some cases the bereaved person reports having developed a style of initiating conversation, particularly with respect to the dead person. Some are thus able to overcome the boundary. In other cases acquaintance- or friendships come to an end as feelings of mutual embarrassment and betrayal take hold.

Avoidance of the bereaved individual by other non-bereaved individuals is matched by an emphasis on the private nature of grief itself. In In Memoriam verses expressions of grief are publicly directed towards the dead. Whilst newspaper offices often carry pamphlets of verses, staff report that bereaved people usually bring in verses culled from previous months' selections, often in a modified or restructured form. In the choice of such public expressions very emotive language is often used. For example:

> Missed with a love beyond all telling
> Missed with a heartache beyond all tears
> Too dearly loved ever to be forgotten by granddaughter
> Dorothy.[6]

Public though they may be, these powerful, explicit expressions of grief frequently include reference to the private nature of the emotional experience of grief. For example (from a man bereaved of his wife):

> No-one knows my sorrow
> Few have seen me weep
> I cry from a broken heart

While others are asleep.[7]

and similarly,

Silent thoughts, tears unseen
Keep their memories evergreen.[6]

also

A secret longing, a silent tear
Always wishing you were here.[8]

Thus feelings of grief expressed publicly by bereaved people towards the dead contain frequent references to the silent, hidden, barely articulated nature of the experience. It is only from within the formalised style and content of these verses that personal choices are made and private feelings declared openly.

Thus those whose close social relationships have been dislocated rather than intensified through the the constraints of the medical model of dying and the professionalizing of disposal may go on to experience bereavement within the confines of a culturally prescribed privacy. In some cases all but the immediate family are excluded. In other cases close human contact of any kind is avoided. Again newspaper announcements of death prescribe a privacy at the time of disposal which, thus established, re-asserts itself through successive annual In Memoriam notices. For example:

Friends please meet at chapel. Afterwards private.

Funeral service on ... followed by private cremation. Family flowers only please.

Funeral private from residence. Friends please meet at church.[9]

Thus at the time of a death customary social separations which prevail in the form of 'privacy' are asserted yet more forcibly in the confining of the experience of grief to within the immediate family or to within the bereaved individual. The possibility of a barrier of some kind between the sense meaning of individual bereavement and the reference of that experience within the surrounding world is thus established. In this way the extended, disorienting process of grief takes place, in many cases, in isolation from experience-within-the-world. It is often only through such 'worldly' experience that the figurative nature of past 'life' can be painfully be brought home and the literal 'death' encountered and then relinquished in order for a changed literal 'life' to proceed.

My discussion of current experiences of bereavement in the West highlights those concepts and those sets of circumstances which serve to dissociate the biological process of dying from the experience of survivors - and which, in the more condensed living/dying context of the residential home, are yet more strenously brought to bear. The belief that this process may, and indeed should, take place within social and emotional as well as biological spheres is the moral stance of the death awareness movement. Having elucidated the boundaries through which process is impeded, I will now go on to discuss the role of bereavement counselling and the hospice in re-creating the experience of transition.

2.4 Managing Bereavement: The example of the Cruse Organisation.

At issue within a hospice and within a residential home for elderly people is the management of the boundary between the categories of experience 'life' and 'death'. Bereaved people's passage through grief can be seen to take place within, or indeed to be centred upon, gaps or boundaries which lie between that individual and their past, present and future worlds. As I have argued, these are boundaries which serve to fuse or confuse the

cultural categories, 'life' and 'death', as experienced by the bereaved person.

2.4 (a) Becoming a Counsellor. Fieldwork in the role of bereavement counsellor takes place not within or inside the experience of the bereaved person but, rather, within the boundary or gap between that person and the rest of the world. Geertz's comment holds true both for fieldwork and for counselling:

> The trick is not to achieve some inner correspondence of spirit with your informants; preferring, like the rest of us, to call their souls their own, they are not going to be altogether keen about such an effort anyhow. The trick is to figure out what the devil they think they are up to. (1977:482)

With respect to the counselling techniques used within the Cruse Organisation, sympathy or even pity felt for the bereaved person is thought to be at best unhelpful, at worst undermining. 'Reflective listening', the primary technique of the Cruse bereavement counsellor, involves hearing what it is that the bereaved person is actually expressing, either in words or through their body, about their experience and being able to reflect back, clearly, what has been heard. It is in this way that the inner chaos of grief can find some external form - that which the bereavement counsellor reflects back - in relation to which the continuing emotional process can be managed by the bereaved person. Similarly the accurate identification of areas which, to the bereaved person, have most significance, and the accurate clarification and summarising of extended, repetitive and often emotional speech are important dimensions of the counsellor's technique. Good field recording rests upon similar skills. In the same vein, fieldwork within a very familiar social context often involves the difficult task of perceiving with fresh eyes all that is assumed and taken for granted. So too counsellors who are widows themselves, though often able to appreciate rapidly the feelings of a newly-bereaved person, must

still work consciously to avoid mis-hearing what is said in terms of their own, particular experience.

Located therefore within the boundary between the bereaved person and their changed social context, the fieldworker/counsellor focusses on what is being told to them, seeking to grasp the constructs through or by means of which that individual experiences and understands what has befallen them. The experiential aspect of such constructs or cultural metaphors has already been discussed.[10] Significantly, the realisation of 'the empty space' arises, over time, out of a willingness to enter privately into one's own emotional experience; to express and explore that experience repeatedly with others; and also to encounter, in the surrounding world, those features which bring home the changed nature of one's circumstances.

Those individuals who seek help from the Cruse Organisation for bereaved people are often experiencing difficulty in one or more of these three areas - for example they may have developed strategies, over a long period, through which painful, irresolvable thoughts and feelings can be avoided; they may lack family or friends willing to enter into prolonged, repetitive discussion of an irreplaceable loss; they may find it impossible, due to their particular personality or the nature of their bereavement, to enter into any contact with the world around them. In the role of counsellor, the would-be helper becomes an agent through which experiences of this kind may take place.

Time spent together by counsellor and bereaved person can be extensive, often continuing until well into the seond year after a death. Weekly visits of between two to three hours, becoming less frequent only after some months, are not uncommon. For very isolated, or indeed very determinedly 'busy' bereaved individuals, an intervention of this extent is not insignificant. In fieldwork of this nature it is therefore important to develop an awareness of how one may become that part of the bereaved

person's social context through which a loss may be realised and made sense of. Rather than participating in the individual's grief, I am allowing myself to be used as one of the intermediary vehicles through which grief may come to take place. One of the most significant aspects of this process is the entry of the counsellor into the private space of the bereaved person's home. Material presented here, and in later chapters,[11] gives insights into the circumstances and the experience of seven of the eleven people I have visited as a bereavement counsellor for the Cruse Organisation.

As will be shown, a visit to the home of a bereaved person can be a powerful gesture on the part of the counsellor. In making such gestures not only the bereaved person but also the counsellor can be made forcibly aware of the 'empty space' and therefore the empty social context which has emerged as a result of the death. After three years' visiting I initiated a Thursday afternoon 'Drop In' for bereaved people in the town centre, together with two other bereavement counsellors. So socially isolated were many of the people I visited that the establishing of a broader social context within which grieving might take place became a priority. In response to their own needs to overcome isolation, expressed at almost every visit, many bereaved people came out to the 'Drop In'. For example, forty-five people visited during the nineteen week period between New Year and May 1985. Over half of them came more than twice, ten returning for ten or more of the weekly gatherings. 'Fieldwork' begun in the private home of the bereaved person was thus extended in the public context of the 'Drop In'. My discussion of the detailed material arising out of visits in private homes is therefore informed by field experience within the broader context of the 'Drop In'.

2.4 (b) Entry. Bereaved people who are visited by a Cruse counsellor have all agreed to such a visit. While some have initiated the contact entirely independently via a phone call to Social Services, the Samaritans, their doctor or, directly, to

Cruse itself, others have been introduced to the idea by a 'helper' of some kind, a relative or a doctor. Whatever the route, initial contact will bring the counsellor into the home of the bereaved person. In this way the counsellor is entering the empty space remaining after the death and in so doing implicitly focusses the attention of the bereaved person upon both the reality of their loss and also their consequent appeal for help. Thus for example:

> Mr Dawlish, an elderly widower, said that his wife had had her bed downstairs in the front room where he had taken me - he pointed out the mark of its foot on the carpet, just in front of me. Obviously I'd sat down just where she'd lain.

The barrier which, to a varying extent, lies between that individual and their wider social context has been bridged through the visit. While relief from isolation may be felt, the bridging of the gulf again involves the focussing of attention upon the loss. Movement across this space, and into the empty space, is therefore invariably a powerful initial act on the part of the counsellor. Responses to it vary.

For those committed to independence and a sense of control over their own circumstances, such visits signal helplessness and as such may not be tolerated beyond a minimum of occasions. Furthermore the raising of painful issues by the counsellor may lead such individuals into areas of emotion over which they have little control - and again extensive visiting will not be tolerated.

By contrast there are others for whom the incursions of another individual into the space which they now occupy alone is an opportunity for the physical re-enactment of the final scenes shared with the dead person in that space. The shared, now figurative 'life' of the past may be performed yet one more time. For example:

> Mrs Jackson, a widow in her sixties, recalled the day when her husband got up from his chair and went to look at himself in the mirror above the fire. As she told me this she got up, re-enacting the event, taking his part. She told me that she herself was sitting on the settee, exactly where I was at that moment. **"By, I've got an awful look"** he'd said, brushing back his hair. Turning, he put his arms around her neck, saying **"Tell me its not so dreadful to leave this evil world"**. All this she acted out, crying as she did so. **"So he knew"** she said, returning to her seat.

and

> Mr Dawlish said he found he had so much time on his hands - after being so totally occupied with his wife's needs. He described in detail all the care he'd given her, getting up to act out having to lift her from one place to another, coming over to almost grasp my shoulders, demonstrating what he'd done.

Most commonly the visit is accepted as relief of some kind from isolation. Nonetheless, whilst entry into the empty space has occurred, the bereaved person may not necessarily make use of the counsellor in order to openly express and therefore enter into their own experience. In very many cases the bereaved person negotiates a path back and forth between an often figurative 'normality' and the literal pain of their loss. It is often only over the period of an extended visit that the many routes back out of painful areas are relinquished and, often in a darkening room, the reality of the loss is encountered. For example:

> (during a visit to Mrs Crawford, a widow in her early fifties) The room darkened towards the end of the three hours and Mrs Crawford began to speak more and more freely, and in more detail, of the events and feelings surrounding her husband's death.

Through the entry and subsequent repeated re-entries of the counsellor the social and emotional process of bereavement may be fostered and managed.

4 IMAGING TRANSITION: HOSPICE CARE

This chapter concludes with a description of the symbolic use of colour, water, the associations of travelling and Christian iconography in the transformation of Challenger Lodge, a large property in Edinburgh - and the creation, in that space, of St Columba's Hospice. It provides a further example of the cultural and social manipulation of awareness which was evident in Strathcarron Hospice. Just as the carefully structured control of awareness within the residential home can be discerned in the more diffuse forms of distancing which go on within the wider society, so the extended, slow- moving process of bereavement counselling has its counterpart in the very condensed symbolism through which a sense of continuity and wholeness is fostered within the hospice.

St Columba's is a large, well-established foundation in Edinburgh. Created within existing property, St Columba's stands beside the Firth of Forth. The former name of the building, Challenger Lodge, is retained within its present postal address. Bearing strong associations with watery travel, it has been appropriated as a framing device through which a sense of a life/ death continuum is fostered. 'Challenger' is the name of the ship belonging to John Murray, an explorer who formerly owned the house. A hospice volunteer brought the name to the attention of patients, handing round the framed picture of the ship from the corridor, saying, **"So we're all on a ship"**. And indeed, prior to the building of new patient accommodation, the tall windows of St Columba's wards overlooked the Forth in such a way that the land which separates the building from the nearby water's edge was invisible. Binoculars in the current day-care room still encourage the eye towards the water. Entry to this hospice now leads the visitor directly into the Chapel, confronting them with the protrait of a staring, misty-haired Christ, flanked by tall

windows which again give onto the Forth. The watery aspect of all these rooms is echoed in the striking predominance of wedgewood or royal blue in the internal decorations, on the external signboard and on the badges worn by all staff and volunteers.

At St Christopher's Hospice in London water is made similarly prominent in a sculpture above the entrance depicting the image of Saint Christopher bearing Christ across the waves. As shown,[12] the creation of Strathcarron Hospice also involved a conscious use of watery symbolism very much in keeping with a similarly deliberate cultural framing of death at other hospices such as St Columba's. In the organisation of space within Strathcarron extensive symbolic use is made of the relationship between the rivers at the periphery of the Central Region and the river flowing through the heart of the grounds.

4 SUMMARY

As noted,[13] those 'non-ordinary' spaces set apart for dying are contexts where 'ordinary' events such as chance remarks, or bodily gestures, readily assume the more profound reference, 'death'. For many bereaved people and for many elderly people living in residential care a spatial and temporal boundary between themselves and the rest of the world can deflect or distort their awareness of such a reference - and impede the process of re-orientation through which the passage from death to life or life to death may be negotiated. I have argued that the entry and the reflective listening of the Cruse bereavement counsellor is a vehicle through which a divisive boundary of this kind may be bridged by a bereaved person. Similarly, for hospice patients whose bodily experience is one of rapid and uncontrollable change, condensed images of watery journeying offer ready referential meanings associated with a peaceful, integrated passage between life and death.

NOTES

1. See Chapter Six, pages 162, 166-168.

2. 'Highfield House', a guide for residents. Durham County Council Social Services Department. Appendix C.
   While the guide's cover refers specifically to Highfield House, its eight enclosed pages are sent out, in appropriate covers, to all the homes in the city.

3. 'Bereavement in Childhood'. Talk given in the Fleming Hospital, Newcastle. Spring 1979.

4. 'Old People's Attitudes to Death in the Twentieth Century'. Paper given at the Society for the Social History of Medicine's spring day conference, 'Old Age'. Oxford, 12.5.84.

5. See Chapter Four, pages 90-96.

6. Newcastle Evening Chronicle. 29.9.79.

7. Durham Advertiser. 5.10.78.

8. Newcastle Evening Chronicle. 17.9.79.

9. Newcastle Evening Chronicle. 1979.

10. See Chapter One, pages 27-30 and 33-34.

11. See Chapter Eight, pages 236-238 Chapter Nine, pages 248-249 and

Chapter 11, pages 322-339.

12. See Chapter Six, pages 173-176.

13. See Chapter Six, pages 164-179.

CHAPTER EIGHT

'PERSONHOOD' DISCLOSED THROUGH THE ENCOUNTER WITH DEATH

Tension between the enduring nature of the social order and the ephemeral nature of its mortal members has been discussed previously.[1] The wide range of ethnographic material presented by Bloch and Parry illustrated the management of such tension through a variety of cultural and social processes. With respect to contemporary Western culture they argue that:

> ...the individual is given a transcendental value, the ideological stress is on his unique and unrepeatable biography, and he is conceived of in opposition to society and his death is therefore not a challenge to its continuity. Moreover, while man's nature may be seen as immutable, the existing social order is not. (1982:15)

By contrast Bluebond-Langner, in a study of the world view of American children dying of leukaemia, adheres to Goffman's notion of a (Western) social order, as one which is constituted through the implicit adherrance of individuals to sets of culturally specific roles, rules and strategies (1978:231-233). Thus an illusion of individual uniqueness or freedom can more be accurately described, using the words of Bourdieu, as:

> ..the intentionless invention of regulated improvisation. (1977:79)

Bluebond-Langner reveals the cultural and social strategies through which dying children in America resist expulsion from the continuum of the social order and therefore avoid social death. In concealing their knowledge of their own condition they maintain the culturally specific nature of the child/parent relationship - i.e. they remain (figuratively) treatable, protectable human beings with futures to be moulded through the care of their parents.

The example of leukemic children, individuals who in dying, unwillingly deviate from the cultural requirements of the social category 'child', raises doubt about the validity of Bloch and Parry's assertion that the relationship between the individual and society in the West is one of opposition. Burridge's distinction between the presence of generalised rather than localised individuality in the West offers a more fruitful approach to this question (1979:32-52). In making a distinction between Western and more traditional societies he concurs with Bloch and Parry. His notion of the Western self, constituted through movement between 'person' and 'individual', is however a more refined and more useful concept than that of a self which lies in opposition to society. Further fieldmaterial will be presented showing that death-related experience can reveal the socially constructed nature of personhood. This occurs, for example, when an ageing, dying or bereaved individual finds themselves outside a former social role. In so doing, death-related experience becomes an occasion par excellence when the implicit moral requirement that the individual should stand aside from and critically regard the 'given' categories of their own society may come, or be brought, into play. It is this idea which, implicitly, is expressed in (former) associations between the death-bed and the confessional. So too in Tolstoy's 'Death of Ivan Ilyich' the central character becomes, simultaneously, aware that he is dying and that 'his life had not been what it should have been' (1960:157). In the same vein the belief persists that as death is encountered so the events of one's past life flash before the inner eye.

Review, repentance and regret are therefore all associated with a period when the individual, willingly or unwillingly, finds themselves at a distance from the personhood through which, in part, they know themselves. As Burridge says:

> ...it is a matter of common observation that most people are in some respects and most frequently persons while in other respects and at other times they can appear as individuals. (1979:5)

Ageing, dying and grieving are, as I will show, 'other times' within which movement from 'person' to 'individual' becomes apparent.

Contrasting material from a non-Western society highlights Burridge's point. MacCormack describes social organisation among the Sherbro peoples of Sierra Leone (1985:117-126). In this social context personhood endures in the form of a 'great chain of being', a continuum made up of ancestors, living people and those not yet born. Unlike very elderly and bereaved people in the West, who are negatively perceived individuals categorised largely in terms of lost membership of a former social category ('adult', 'wife', 'husband'), the Sherbro move continuously through a succession of social roles. MacCormack describes dying as:

> ...a period of categorical ambiguity in which a person is still among the mundane living, but babbles of the past, a sign that he or she is also in the process of becoming one with the ancestral shades. (1985:117)

Senility is thus positively perceived, an indication that the very elderly person is in close communication with otherworldly beings who are the ultimate source of blessings and misfortune. Specific ritual forms appropriate to this period of life ensure smooth passage between social roles.

My first (Western) example is the elderly people whose frailty or senility is managed through residential care. I will show that they are perceived largely in terms of their material needs - and that the giving of physical care exposes both staff and residents to individuality of a kind which no longer finds expression in

accepted, acceptable social roles. I will argue that in a Western society where movement between 'person' and 'individual' is an everpresent if implicit possibility, staff's exposure to residents' painful experience of individuality is an unwelcome reminder that they too may 'outgrow' the social roles within which they are currently imbedded - and that it is growth of a kind which implies decline, deterioration and death.

1 THE INSTITUTIONALISATION OF MARGINALITY AMONG VERY ELDERLY PEOPLE

One of the first jolts experienced by the (non-elderly) fieldworker entering a residential home for elderly people is that their notions of the scale and the stages of the human life cycle no longer fit. Those who live in the home are very, very old. Many of them were born some years before the outbreak of the Boer War, one or two being already in their mid-teens at the time of Queen Victoria's death. Seemingly the residents belong in a history book rather than a home. While individuals who die before the age of seventy may well leave gaps - empty social roles, ruptured relationships, unfinished business - those who survive the age of eighty may find they have toppled over the edge of the social 'map'. Within the home elderly people often comment:

> **"I've outlived my generation."**
>
> **"Most of my friends are ... (dead and gone)"**
>
> **"My generation has gone. I'm 85 that's old enough."**
>
> **"All my generation has gone now; only the dregs are left."**

With the loss of one's generation comes the loss of all the networks of professional, social and kinship roles within which one was formerly imbedded. In their seventies, eighties and nineties, elderly people may become prominent as individuals, marginal to the rest of society. Their homes, or their

membership within the households of the next generation, may be withdrawn from them and, perhaps for the first time, they are singled out by the 'Authorities', the medical and social services.

By pressuring elderly individuals into accepting residential care their marginality is recognised and contained within a space which is physically, socially and structurally marginal to the rest of society. It is transformed into an institutionalised marginality. Entry to residential care is therefore the experience of individuals no longer able or perhaps willing to live out the requirements of their former social roles. Their awkwardly prominent individuality is managed through the imposition of the social categories of the institution.

Within the home, membership of one category or the other - staff or resident; Matron or Care Staff; 'fit' resident or 'frail' resident - is given material expression at all times. Thus, residents eat and drink from sterilised plastic crockery, care staff use chipped, unsterilised mugs and plates, and the Matron and her deputies have exclusive use of a matching dinner and tea service. The style of dress and the use of space for washing, eating and relaxing is also different and separate for the members of each institutional category. So rigidly and visibly is social category expressed that the passage of any one individual through the institution has little impact. While the Matron and her deputies work in daily rotation, care staff change shift at eight hourly intervals and residents pass through the home in a matter of weeks or years. The absence or permanent loss of the individual is thus made irrelevent to the daily unfolding of this hierarchical pattern of social categories. At the death of a resident their room, clothes and dining room place are soon assumed by another member of the category. No visible record of their presence within the home remains.

This overdetermined expression and separation of social category corresponds to the rigid structuring of institutional time and space. In the case of the latter system, one which involves the maintenance of 'normal' rules of eating, sleeping, hygiene and dress, its rigidity can serve to intensify a resident's awareness of changes which are taking place within their own bodies. For example a frail stroke victim may spend fifteen minutes walking the fifty yards from their bedroom to the dining room in order that a meal shall be eaten at the time which is appointed for those categorised as 'resident'. During this period the elderly person is inevitably made uncomfortably aware of their immobility, finding it difficult to use speech to deflect their consciousness from the interminable nature of the journey. A painful sense of individuality arises out of an attempt to conform to the timetable set up for all the members of one social category. As the journey is repeated at every successive mealtime, the increasingly extended period of time required serves as a reminder of the process of deterioration which is taking place.

The same awareness of individuality is brought about through the stressing of social category which sanctions a physical closeness not customarily found outside relationships between parent and child or between sexual partners. Thus in the roles of resident and care assistant, individuals continuously share intimate contact in bathrooms, bedrooms and toilets. Through personal care of this kind the literal reality of the ageing process is controlled and distanced, thereby making the promotion of a figurative reality possible. Nonetheless it is often at the end of these spatially confined interractions that a resident will insert a joking/threatening expression of their (individual) closeness to death. Similarly care staff, whether in seeking to care for or to control a resident, are repeatedly exposed to situations which evoke a personal, individual response.

Thus, for example, the care assistant who assists the frail stroke victim to walk the corridor to her meal is herself constrained and made very physically aware of the unconscious ease with which she, as a younger individual, can make the otherwise very brief journey. A range of personal feelings may arise. For example, she may feel compassion and question the value of imposing movement upon the very elderly handicapped person; she may feel frustrated, fatigued and bored by the physical constraint being imposed upon her or she may feel a sense of tongue-tied inadequacy if she attempts to alleviate the unpleasantness of the resident's experience. In addition she has to manage an extended period of physical confrontation with the conditions of old age. All these feelings must somehow be subsumed within the working role of care assistant.

In summary, while residents are continuously made aware of the ageing process as they move here and there according to the requirements of a rigidly repetitive institutional system, so care work, similarly, involves staff in the literal confronting and then figurative distancing of elderly individuals who are moving through a difficult and often lonely stage in life.

A very young and inexperienced care aid gently pinched the wrinkled skin on a resident's arm, commenting reflectively - **"That's how your skin goes"**. A resident's photo of himself among former police colleagues, taken in the 1930's, led her to wonder aloud how many of them were dead, to comment on the swift pasage of time and to wonder what she'd be like when she was old. Such thoughts must have been common among new staff, yet this form of overt expression was very rare.

The uneasy awareness of individuality produced through the imposition of institutional categories is managed by staff in a variety of ways. These include a stressing of group style among themselves - and a vigilant control of the expressions of

individuality offered by residents.

1.1 Nice-natured Women.

Among those categorised as care staff, conformity to a very well-defined style prevails and these individuals can be said to constitute a distinct social group. Membership of this group is very positively perceived and relationships within it are characterised by deference and a desire to please rather than offend. To appear **"canny"** or **"nice-natured"** is to qualify for acceptance. Any requests for help from one staff member to another are delicately prefaced by phrases such as **"if you don't mind"**, **"if you've got a minute"** or **"could you do me a favour"**. Care assistants compete with one another to answer the summons of a bleep which interrupts a coffee-break. Similarly, the exchange of cigarettes or small food items between staff invariably follows a complex pattern of offering and refusing, offering and refusing, until finally the gift is placed firmly in front of the would-be recipient. Frequently care staff can be found with several unsmoked cigarettes lying before them on the staff room table.

Those who fail to conform to the style adherred to within the group are silently but strenuously excluded. An over-effusive or noisy manner in dealing with residents, a tendency to work at the wrong pace or an unwillingness to work hard can all lead to a staff member finding themselves permanently seated at the more visible and less sought-after of the two tables in the staff room. Yet even this process is subtly accomplished, accepted members of the group being unwilling to risk censure through the overt expression of critical personal opinion of another member, whether present or not.

This striking solicitousness of each other by the staff, the carefulness with which they continuously interract with one another has the effect, even purpose, of creating and maintaining a cultural solidarity which serves to define and express their

identities in the home as caring staff rather than as individuals. The ethos of care, customarily employed in the management of residents, is also used in such a way as to seal off staff from residents. It provides the staff with a corporate means of protecting their individual vulnerability during the stressful contact with ageing/dying residents. In a context of care the cultural elaboration of this caring style helps distance the care givers from the care receivers by providing a conformist and well controlled model for caring behaviour. In this way individuality is subordinated to a concept which defines and separates that caring category for whom a future remains.

Only once was the shared fate of both staff and residents made explicit. It took place in the staff room when one of the older care assistants reported the discovery of her post menopausal bleeding and bluntly declared her fear of cancer. Profound silence greeted this confession and minutes elapsed before the jokes and the rationalisations could be mustered in response. An explicit intimation of mortality had crossed the barrier from residents to sit among the staff, thereby posing a particularly overt challenge in the exposure of the vulnerability of one staff member to the care givers as a whole. The unwelcome challenge was met with the only appropriate response - silence.

The submerging of their own individuality by staff is complemented by other institutional processes through which inevitable manifestations of the individuality of residents are interpreted and controlled.

1.2 Making History: a record of dying.

Perhaps the most succint and concrete example of this form of control is the Report Book. Lying open on one of the staff room tables, it is permanently accessible and frequently read by staff - for interest as well as information. Every eight hours, at the change of shift, they list the dozen or so names of residents who have become prominent as individuals, whether through illness or

through some particular form of behaviour. Beneath this list the additional sentence,

> Remaining residents no change at the time of report.

encompasses the anonymous majority who have adherred to the behaviour required of those categorised as residents. Prominence is thus achieved by those who have failed to conform. Reputations are built from the noteworthy events of each eight hour shift.

For example, when Mabel Edgar, an eighty-nine year old resident, was finally moved from a double to a single bed-sitting room, she declared herself **"as happy as a pig in shit"**. In an environment purged of bad language the humourous vulgarity of Mabel's remark resonated throughout the building. Its entry into the Report Book brought it to order, the utterance of the word 'shit' sanitized through the use of the letter 'S' followed by a blank line.

Similarly, when Granny Foster assertively offered night staff 10p to turn off the corridor light outside her room, her name too appeared in the Report Book.

> Granny Foster is now into bribery and corruption.

The morning after Gertie Swinburn, ever wakeful, had slept until 5 a.m. a care assistant made the following entry:

> Gertie Swinburn made history - slept until 5 a.m. The little darling.

As the common property of the staff group, the Report Book is a vehicle by means of which the individual responses of its members are transformed to become the jokes, the comments and the castigations of the group. In this way staff culturally manipulate the behaviour of those categorised as residents by

singling out those who fail to conform. When a resident apologised for speaking harshly to a care assistant the reply came back:

> **"That's alright but we get annoyed too you know - and we're not allowed to say anything."**

By making explicit the constraints on individuality among staff, the care assistant both accepts the apology and attempts to put the elderly lady in her place, back among the residents where her individuality may become less perceptibly troublesome. The exchange was later reported to another care assistant who commented:

> **"Well, that's something, an apology from Mrs King. That's going down in the Report Book."**

In this way the force of a confrontation between two strong personalities was dissipated, brought to its conclusion in the pages of the Report Book.

The vigour of these and many other of the entries within this record, testifies both to the distinctiveness of particular experiences of old age and also to the singular acuteness of staff's responses to those who undergo them. Written just prior to leaving the home at the end of a shift, the Report Book offers care staff a means of reflecting on and giving order to the fragmented and often overlapping experiences of the eight hour shift. In her chosen use of language, the staff member invariably leaves behind her a record, not only of particular events, but also of the style in which they were managed.

The Report Book can therefore be seen as a cultural interpretation of a struggle to retain fading individuality on the part of residents and a struggle to restrain such intrusive individuality on the part of staff. This restraining control of

resident individuality is transformed in the record, by humour, into a guide for the successful and caring manipulation of awkward events which otherwise might disrupt the rhythm of life in the 'homely environment'. Edited and summarised in the pages of the report book stand the lives of those who have outgrown the social categories of their own society. As argued in Part One of the thesis 'life' is, currently, a limited and excluding category of experience. Separated off from 'death', 'life' refers to a concept and an experience which precludes any association with decline or loss - and social death in some form is the fate which threatens those unable or unwilling to conform to its limited models.

In the material presented so far, the movement from 'person' to 'individual' is often painfully permanent. Individuality of the kind experienced by elderly people can be a form of social death which intensifies the future prospect of loneliness at physical death. Conversely, movement out of a particular social category can confer the freedom to regard and reassess from a distance the categories through which one has lived. As the report book shows it is a possibility which residents often resort to, at times with a freedom which disconcerts the carer.

2 "...PEOPLE THAT'S LONELY AND SUFFER WITH THEIR NERVES"

Like very elderly people, those who are bereaved may also find themselves on the fringes of society. Often they may be wholly avoided if their manner of grieving is perceived to be socially inappropriate. There they may come to be associated with other marginal social categories, 'the handicapped', 'the mentally ill', 'the lonely'. This practice is illustrated by the reported experiences of individuals who seek help from the bereavement organisation, Cruse.

First the example of Mrs Crawford, a wealthy woman, widowed and in her early fifties. Her mobility - and social life - is frequently curtailed by rheumatoid arthritis. She lives alone in a comfortable bungalow. Her only child, a daughter, is married and lives in the south of England. Her husband had a senior post in the local social services department.

At present Mrs Crawford is visited by a social worker who has arranged for her twice weekly visits to a centre for handicapped people in the city. Mrs Crawford was so desparate that she went - and continues to go - despite the fact that she finds contact with severely handicapped people very depressing. She feels that she takes their burdens home with her. She found the first day at the centre upsetting as no-one was there to meet her or take her round the place. At lunch time she found herself having to walk right around the dining-room, alone, looking for a place. Eventually she found one place at a table with a blind person and two severely handicapped people who could not communicate. Even so she intends to persevere - it gets her out of the house.

Mrs Crawford's neighbour has been to the Singles Club with her once - but says its not really her kind of place and doesn't really think its Mrs Crawford's kind of place either. Mrs Crawford said she knew it wasn't but she felt she had to go along and make the best of it. Sometimes she wondered what she was doing there - a year ago she would never have gone to such a place. However she feels some of the people there are very nice - and has obviously been very successful in getting to know them.

Mrs Crawford said that the men at the Singles Club were **"pathetic"** and **"roughly spoken"** but she **"just kept herself to herself"** - they must be lonely too. Her lady friends are close - she feels relaxed with them. It was surprising how people **"reached out to one another"** when they were on their own -previously she'd felt she couldn't make new friends now that she was older.

Similarly there is the example of Mrs Jackson who is widowed and lives alone in a small terraced house in a County Durham mining village. In her sixties, she is healthy and has family living locally. She has no employment outside the home but is financially independent. Her husband was a builder.

> The community psychiatric nurse had told Mrs Jackson that it was up to her to improve things - but had suggested a day centre "**for people that's lonely and suffer with their nerves**". Mrs Jackson feared that she'd be put with mentally ill people.
>
> Mrs Jackson had written a letter to a friendship bureau in a nearby town. She'd written 'if you could bring a friendship to me, I'm sure my grief and depression would soon heal.' She described herself as 'quiet and home-loving'. She told me she didn't want a husband. However she is wary of the bureau and unsure whether to post the letter - her phone calls have only been met by an Ansaphone.

These examples show that an association with institutions such as day centres, Singles' Clubs and friendship bureaux can heighten a bereaved person's perception of themselves as now excluded from the positively perceived social categories 'wife', 'husband', 'family' - and, increasingly, defined by others in terms of the negatively perceived categories 'handicapped', 'lonely' and so on. Made peripheral to a former social identity, a bereaved person, in choosing to resist negative re-categorisation, may begin to pursue chance social encounters. As the following examples indicate such encounters often bring contact with other individuals bereaved or lonely in a similar fashion. And again, in some cases, such meetings can reinforce a sense of personal hopelessness.

Mrs Crawford has struck up a friendship with a widow she met in a bus queue - **"you get so desperate you'll try anything"**. Again this widow lives too far away for visiting but they have phoned each other and Mrs Crawford hopes they will get together.

Another example is Mrs Patterson, a divorced woman in her mid-thirties whose third child died, aged two, of a rare disease of the nervous system.

Mrs Patterson told me she had met someone at the holiday camp who had lost two children with spina bifida. The woman had one child of her own now and one adopted child. Mrs Patterson commented on the strangeness of this chance meeting with someone who had also had a tragedy. The woman had been very upset to hear what had happened to Mrs Patterson. She said she never really got over the deaths of her children. Those she had didn't replace those she'd lost. She was aware of the dates at which her dead children would have started school if they had lived.

Mrs Jackson told me of an elderly lady, seventy-eight years old, living in the Aged Miner's Cottages nearby. Mrs Jackson found her wandering in the streets one night, desparately lonely, and only able to recognise her own home by the ornaments in the window. She'd begged Mrs Jackson not to leave her, to stay all night. She was widowed and isolated from her grown-up sons. Mrs Jackson only managed to stay for twenty minutes as she found the lady's ramblings very wearing. She'd urged her to go out, had tried to encourage her - the lady felt suicidal and Mrs Jackson tried to comfort her. **"And I'm telling her all this when I feel just the same"** said Mrs Jackson.

Mrs Jackson feels she is frightened, running away from **"the fear of loneliness"**. She's tried visiting a very elderly widow, recommended by the doctor. The widow still cries three years after her husband's death. She works from morning to night, its her way of coping - the house is spotless. She said its not much of a life after being widowed. Mrs Jackson doesn't think she'll go on

visiting.

Such material reveals individuals severely constrained within contexts where social models of bereavement are either uncertain or lacking. With little by way of 'guidance' as to the management of an overwhelming emotional experience, bereaved individuals can find themselves confined indefinitely within the empty spaces of the home, able to share that experience only with members of other negatively perceived social categories. As the material illustrates, it is in situations of this kind that those individuals who seek help from a counsellor often find themselves after a bereavement.

Unlike very elderly people living in care however, younger adults who come to pass out of the social categories 'wife', 'brother', 'son' or 'mother' may anticipate future re-entry into the same or new social categories. Despite a strong and explicitly described desire not to re-awaken to yet more empty days, bereaved people may simultaneously seek assurances that their present experience of social and emotional loss is transitory. In bereavement counselling the offer of such a hope is one of the most common and more tangible forms of help given.

3 REVIEW, REGRET AND REINTEGRATION: THE HOSPICE RESPONSE TO DYING

As shown previously,[2] the process of grieving involves the individual's repeated re-living of their former life's experience, a reassessment of their social role 'wife' or 'husband'. The expression of long-held, carefully silenced regrets or resentments is in every sense an often critical dimension of such a review.

While passage out of a familiar social role or category can become a form of social death, social support or counselling can also facilitate a creative transformation of this experience. Not only regretfulness but also renewal and reintegration are responses which can be brought about by the movement from 'person' to 'individual'. While a bereavement may precipitate a long-withheld possibility for change and expansion, so dying, as managed within the Hospice Movement, can become a process which brings resolution and a sense of completeness which previously was lacking.

The realisation of this possibility is one of the Hospice Movement's explicit aims. Indeed as a transformative organisation its goals are carefully formulated and published in its educational material. In unpublished 'Notes for teachers on dying, death, grief and bereavement', the administrator of Strathcarron Hospice defines the Movement's educational goals as:

> On the one hand to unlock the inherent capacity for responding to the actual events of death and bereavement, and on the other to encourage a more wholesome stewardship of living within the bounds of our mortality.

He goes on to say:

> As someone learns to grieve about his own death he is the better able to identify the business he wants to finish - the relationship he wants to reconcile - the memories he wants to share - the hopes he wants to pass on. He can voice honestly his doubts and raise questions about his faith. He can be helped to face and answer the ultimate questions of living - what does it mean ? - what is the purpose ? - what happens next ? The Hospice seeks to create an environment where this kind of honesty can be the key to answering fears, doubts and loneliness with faith, hope and love.

Cicely Saunders, the founder of St Christopher's Hospice in Sydenham, London, describes this period in the following terms:

> At this stage so many of the superficial things that people care about have fallen away and they're left with reality. It may be a tough reality, but it is a chance for families to come together in a new way.[3]

Saunders thus expresses the Hospice Movement's implicit acknowledgement that as death approaches the roles and categories of everyday life have 'fallen away'.

In explicitly classifying a patient as 'terminal' a very particular social category and social context is established. As I have argued the aggressive medical prolongation of 'life' does not openly admit the category of experience 'dying'. If death is seen largely as the result of medical failure, then that period which precedes it is stoutly (medically) defended as 'life' - and hence the 'quality of life' dilemmas exemplified earlier.[4] Most significantly therefore the hospice can be seen as a cultural context which explicitly admits the category of experience 'dying'. In acknowledging rather than masking this area of human life, Hospice ideology represents a more expansive and expressive metaphoric framework. And in acknowledging the experience Hospice care addresses itself to the fear and suffering which it encompasses. As Geertz says:

> As a religious problem, the problem of suffering is, paradoxically, not how to avoid suffering but how to suffer, how to make of physical pain, personal loss, worldly defeat, or the helpless contemplation of others' agony something bearable, supportable - something, as we say, sufferable. (1968:19)

Once reclaimed and admitted into lived, sufferable experience the possibility of 'accepting' and 'coming to terms with' dying emerges. Hence the resonance of phrases much quoted within the

Hospice Movement:

> We will do all we can to help you live until you die (Saunders, 1976:6)

and

> In the midst of death we are in life.[5]

In Strathcarron Hospice those categorised in this way are perceived to have moved beyond the restrictions and the conditions of the external world:

> **"They're really spoiled here, they deserve it."**

The open and unbounded quality of the relationship between Strathcarron and the local community, expressed in the image of the river valley, is recreated within the hospice itself in the tolerant and trusting relationships existing between patients and staff.

For example patients can be prescribed drugs in high and frequent doses. One such patient, cared for at home in difficult circumstances, was taken for a holiday to a nursing home in a different area by the hospice social worker. When the social worker offered the exhausted patient sherry after her journey, she incurred the disapproval of the Matron of the nursing home. Hostilities between the Matron and the hospice became more open still when the Matron later discovered not only the quantity of drugs which the patient was consuming but also the fact that she was permitted to administer them herself.

High drug dosage, unconstrained by problems of future addiction, is echoed in the expansive quality of social relationships within the hospice. Staff draw upon a Christian ideology, an important theme within the institution, to offer a very immediate and a very accepting warmth towards patients and colleagues. Patients'

wants and needs, however complex and idiosyncratic, are identified and discusssed extensively by staff. Whenever possible they are met. The social worker chose to drive home a day care patient well before the end of her visit when she announced, without warning or indeed any overt reason, that she wanted to leave. Another doggedly independent patient established the practice of phoning the hospice for a bed whenever she felt like coming in - and discharging herself when she was ready to go home. Staff talked admiringly of the way she **"treats the place like a hotel"**. A home care patient, in his forties, whose particular form of cancer necessitated both a high drug dosage and a colostomy bag was warned not to drive. The home care sister smiled acceptingly when she told me that he chose to ignore this warning.

In summary the Hospice Movement, in openly accommodating dying people offers the conditions within which a social category 'the dying' may be established. In its nature it is entirely unlike the institutional category 'resident', one which is rigidly imposed upon the roleless individual. The social category 'dying' is about the individuality of each and every one of its members. Being free to dispense with the duties and obligations of former social roles, yet, being constrained within their rapidly diminishing lifespan, 'the dying' are enjoined to re-order their affairs as individuals who are explicitly set apart within the social category 'dying'. Again Saunders sums up the Movement's approach to those individuals who have been carefully encompassed within the social category 'dying':

> You matter because you are you. You matter to the last moment of your life, and we will do all we can to help you not only to die peacefully but also to live until you die. (1976:6)

4 SUMMARY

In this chapter the theme of a separation between the cultural categories 'life' and 'death' is again taken up. The movement out of a particular social category leads into the divisive boundary between life and death. In this space individuals such as frail elderly people or very isolated bereaved people can find themselves to be without a social role. Discovering themselves on the margins, outside looking in, such individuals may disturb or criticise the cultural and social categories which represent the centre. As the material presented shows, they may be brought rigorously to order, e.g. within the institutional categories of Highfield House, or they may be ascribed membership of distanced, negatively perceived social categories, for example 'the handicapped' or 'the mentally ill'.

As I have indicated[6] the movement from 'person' to 'individual' is grounded in the emergence of Christianity and the inception of a generalised individuality in the West. In keeping with its Christian foundation the Hospice Movement seeks to expand upon the creative possibilities of the dying space between life and death. In acknowledging the rolelessness of terminally ill patients the Movement fosters the reviewing of former cultural and social categories with a view to the reintegration of the whole person, and their family and friends, prior to their death.

NOTES

1. See Chapter Three, pages 70-73.

2. See Chapter Seven, pages 201-203.

3. Quoted in 'A day in the life of Dame Cicely Saunders'. The Sunday Times, Colour Supplement, 19-2-84, p.70.

4. See Chapter Three, pages 75-80.

5. Caption to an article about Cicely Saunders. Guardian Women. 20.2.84.

6. See Chapter Three, pages 70 and 72-74.

CHAPTER NINE

CARE AND CONTROL; THE MANAGEMENT OF POWER

> Winnie Elliott, a resident of Highfield House, had been in sickbay for more than four months, categorised by staff as 'frail', 'likely to pop off soon'. When Jan, a care assistant of about twenty, entered the room Winnie said, **"I'm fed up". "Well, I am too, Winnie."** replied Jan. **"Well, you took the job on, I didn't."** answered Winnie. Sue held a clenched fist to Winnie's face and Winnie laughed.

This simple exchange of joke and counter joke exemplifies a gentle wrangling over power which goes on continuously within Highfield House. Bedbound and alone Winnie, predictably, is fed up. Jan can do little to alleviate the situation. Jan jokingly claims to share Winnie's boredom, figuratively setting herself up as Winnie's equal - which in reality she isn't. Yet implicitly the same fate may await her. Winnie jokingly blames Jan for taking on the job of caring for her, care upon which Winnie quite evidently depends. And yet Winnie suffers in her confinement behind bed bars. Finally Jan, powerless to terminate Winnie's suffering, offers a clenched fist, mockingly asserting a physical power which she has and yet cannot use, in the face of Winnie's joking rudeness. And Winnie laughs in the face of the mock aggression just as the dependent child laughs when tickled by its more powerful mother. At the end nothing has changed. They have played with the forms which constitute their situation and their relationship but the episode has altered neither the constraints of Winnie's physical helplessness nor the limitations of the institution. Winnie has been able to claim a little attention and Jan has been able to make her laugh. By being rude to each other they have asserted the sense of closeness and intimacy which they have developed in the course of their extended relationship.

Condensed within this fleeting incident are many of the issues and paradoxes which lie unreconciled beneath the surface of institutional life. In unravelling this 'gentle wrangling over power' a tension between the concepts of care and of control becomes apparent. As I will argue, this tension can be seen to permeate the wider society within which the residential home is set - and to materialise in the jokes, rationalisations and dilemmas which pattern everyday encounters between the carers of Highfield House and their dependent charges.

1 IN AND OUT OF CONTROL

A cultural perception of the natural or material world as being amenable to human control and dominance is, as I have shown,[1] one which has been gaining ground in the West since the beginning of the sixteenth century. It is within this context that medical skills, knowledge and technology have come to assume a powerful curative role vis a vis the human body. By the same token bodily or emotional suffering which proves resistant to medical control, in assuming an uncontrollable disordering aspect itself becomes powerful.

Bereavement counselling provides an example of the responses evoked by suffering within our own society. While the notion that 'it helps to talk over problems with someone else' is commonly held to be true, bereaved individuals who approach Cruse are often very desperate to alleviate the painfulness of their own circumstances through some more immediate means.

Thus whilst there is an acknowledgement that talking and emotional expression such as crying may help, there is also the contrasting notion that problems have solutions which can be pursued in a linear fashion through the engaging of a strong will. To dwell repetitively upon apparently irresolvable despair

is frequently given cultural and social discouragement. Similarly the detailed pursuing and the expression of painful emotional experience to its ultimate limits is not perceived as a forward-looking approach to problem solving. It is thus often only with time that the bereaved person recognises that the counsellor will listen, both intensively and extensively, to such talking - and that they will stay present throughout prolonged and powerful expressions of grief or anger. Doubts nonetheless often remain within the bereaved person as to the efficacy of such a process and the meandering back and forth between a figurative 'normality' and a literal despair tends to prevail.

In addition these doubts are not confined to the individual suffering a bereavement. The training of counsellors involves challenging the idea that 'help' means resolving or removing problematic emotional pain. In place of this assumption an awareness of the spiral path into and through suffering is cultivated. The counsellor is seen as one who accompanies rather than acts upon the bereaved person. Nonetheless, despite training, the idea that 'helping' means solving or removing suffering can be deeply imbedded and the counsellor's more passive accompanying role often brings with it a feeling of discomfort or uneasiness. Thus counsellors can discover themselves diverting their energies towards more practical problems such as health or housing. Fieldnotes reveal my own experience of these feelings when first making a visit in the role of Cruse counsellor:

> Mrs Crawford looked solemn, puffy-faced and slightly wet-eyed. She sat me on the end of her sofa, taking a chair close by herself. Perching on the corner of her chair she leant forwards towards me. Very quickly she told me that her husband had died in November. She'd spent time with her daughter in Sussex but when she was at home she felt very lonely and depressed. She thought I might be able to help her. She told me this hastily and urgently, large wet eyes close to mine. I felt somewhat overcome by this directness. Much as I had feared, here was someone desperate for a lifeline - one I felt both obligated to offer yet

> very aware of not being able to produce. I had to struggle against my nervousness and self-consciousness in these new surroundings - and to guard particularly against just not taking in what she was saying.
>
> After Mrs Crawford's initial description of events and emotions, I began to feel anxious that my passive and self-consciously sympathetic listening was proving a disappointment to Mrs Crawford. I felt I had to hold back my few pieces of advice and comfort for later and not plough into her grief too fast. She leant back in her chair, talking in an apparently deflated and less urgent style. I felt I must seem so much younger than she was - and so evidently not in possession of any profound resolution to her misery.

The idea that 'problem solving' is a cultural concept specific to the West is echoed in an example used by Lakoff and Johnson in their discussion of metaphor (1980:143-144). In the statement 'the solution of my problems' the word 'solution' was (mis)understood by an English-speaking Iranian student to refer metaphorically to the chemical process of temporarily dissolving substances (problems) in liquid, out of which other substances (problems) would be precipitated. Viewed from such a (non-Western) perspective Lakoff and Johnson argue that:

> Problems would be part of the natural order of things rather than disorders to be 'cured'.

Illich too makes a distinction between Western and more traditional responses to pain. He writes:

> Culture makes pain tolerable by integrating it into a meaningful system, cosmopolitan civilization detaches pain from any subjective or intersubjective context in order to annihilate it. (1975:93)

1.1 The Commitment to Care.

In conjunction with, but in opposition to, a Western view of a controllable natural world stands the concept of care.

As noted[2] the Graeco-Roman imperative to explore and understand the cultural and social categories of others has become fused with Christian doctrine which interprets the transgression of category as the pre-condition for an all-encompassing love. The New Testament Gospels offer repeated examples of the expression of such a concept of love. Indeed they are grounded in the belief that:

> God so loved the world that he gave his only begotten Son to the end that all who believe in him should not perish but have everlasting life.[3]

In earthly form his son Jesus Christ fosters such a concept of love through the parables of the Good Shepherd who cares for the frailest of his flock,[4] the Good Samaritan who leaves his chosen path to care for the sick,[5] and the father who extends unconditional love to his undeserving prodigal son.[6] This theme is echoed throughout the gospels, both in the teachings and in the life of Christ.

Within contemporary Western culture 'care', grounded in a Christian concept of love, and 'control', grounded in a post-medieval scientific view of the natural world, co-exist in uneasy proximity. In a secular, state-run institution such as the residential home 'care' is offered within and through structured channels of control. Just as religious belief and practise are regarded in this context as matters of individual choice, so 'care' is offered in the form of individual acts of humour, generosity or ingenuity. Remaining always in tension with one another, control, as a limiting, dehumanising practise, readily evokes the cultural requirement for care - and care, a form of love which brooks no discriminations or constraints, rapidly brings exposure to 'problems' and the cultural requirement that they be controlled.

1.2 The Power of the Weak.

As I will show, ageing in residential care is managed not only in the face of but also by means of the tension between these two modes of thought and practice, 'care' and 'control'. Thus Winnie and Jan manage their respective experiences of ageing through a gentle wrangling which brings care and control together in quietly humourous ways. Confined behind bedbars Winnie is committed to care; uniformed in institutional space Jan is committed to caring for her. Both individuals are subject to the limitations of the human body and the controlling structures of the residential home. While Winnie's figurative 'rudeness' and Jan's figurative 'violence' readily evoke the literal disorder which might ensue if individual feelings were given free rein, the sense of daring is confined, quite safely, to the realm of the imagination. It is a matter of laughter rather than subversion. This finely tuned balancing of care and control can be contrasted with the disorder precipitated by an individual whose choices, while minimal, were less restricted than Winnie's.

Annie Crosby, a wealthy woman in her eighties, had recently returned to her birthplace in the North East to be near her sisters. Supported by the home help service she lived alone in a modern flat, one which she found much to her liking. As one of the first five women to graduate from the nearby University in 1918 Annie had many treasured associations with the area. Her education remained a useful resource as fairly serious reading kept her occupied and alert. Nonetheless, despite her assets, Annie found herself in a socially marginal and isolated position. She was widowed and childless, a hysterectomy having followed the stillbirth of her one baby. She told me

> **"Once you lose your partner, if you have no family, the world drops around you, drops completely."**

Her widowhood she described as **"seven lost years"**. Grief marred her visits to old friends in Lancashire, her former married home. Arthritis curtailed her outings to old University haunts in the North East. As she explained

> **"I'm very proud. I don't like to be an exhibition."**

In addition the ties with her sisters which drew her back to the North East were no longer viable to the extent she would have liked.

Annie was offered 'care' in Highfield House between 10 a.m. and 4 p.m. on several days of the week with a view to her eventual admission as a permanent resident. Both the authorities and Annie herself had perceived the difficulties of her marginal social situation. In her possible admission to residential care, to a space which is physically, socially and structurally marginal to the rest of society, lay an acknowledgement of her situation.

Being sufficiently independent to retain her freedom Annie, the 'day-care', viewed the implications of admission with scepticism. She said:

> **"I've discovered that I could never live in this. I would get so I was sitting about doing nothing, or I would go potty...some of the residents drive me mad. They never have a book or a paper...if I couldn't read I would die."**

It was a case of **"Abandon Hope all Ye who enter Here"**, she'd told a friend. Such vehemence was rare from settled residents. Lacking choices or alternatives, they were more veiled in their allusions to the systems of control through which their 'care' was administered.

In clinging to a social role which she could no longer sustain Annie, and the care staff, became forcibly aware of the uncontrolled processes of her physical deterioration. As loneliness and physical handicap dogged her attempts at independence Annie became increasingly low-spirited. In caring, intermittently, for Annie, care staff were exposed to an unpleasant smell, the product of her mild incontinence and her restricted washing habits. This they resented strongly. Had Annie been admitted to permanent care the deterioration of her body would have been brought under control.

Annie hesitated. She was bathed rather precipitately one afternoon, her soiled clothes removed for cleaning and, as another resident said:

> **"they put other people's clothes on her after her bath".**

Bathing Annie brought staff forcibly into contact with uncontrolled physical deterioration. The personal smell of permanent residents is controlled through regular baths, each one carefully logged into a record book. Annie's uncontrolled smell offended - not only on a physical but also a cultural level which is specific to parts of the North East. As members of mining communities with an economic base involving unavoidable contact with dirt, many care staff perceive personal hygiene as a sign of highly valued respectability. They stress that right up until death, their mothers:

> **"kept themselves spotlessly clean, spotlessly clean."**

Annie's smell confronted staff with the literal reality of old age. Only by drawing on their knowledge of her wealth could they dispel the power of uncontrolled physical deterioration. In implicit contrast with their poor but spotlessly clean mothers they described Annie's 'dirtiness' in class-based terms. Thus:

"That's always the way. You find its the rich people that are the dirtiest. I can see Annie just sitting by the fire all day, eating - like a little pig."

Annie, for her part, finding herself both offered and given a bath on the same afternoon, was also forcibly confronted with her own physical frailties and the dependency which she tried indefinitely to postpone. In a similar vein to the staff, Annie too invoked a cultural perspective, transforming a threat to her personal independence and power into a question of bad manners. In an implicit allusion to the staff's working class origins she described the rapid offering and then giving of the bath on the same afternoon as **"not etiquette"**. As the baths continued to be given, she preserved her lady-like status by treating the Matron's apparent bad manners as an eccentricity:

"I'm tickled to death about these baths", she said. **"I wash down every day at home".**

Avoiding outright rudeness, she told me guardedly that she:

"didn't care for the Matron".

Annie's class-based statements are a powerful affirmation of her own past independence. 'Bad manners' is the cultural concept through which she refers to the systems of control which threaten that independence. The distance which she places between her own social background and that of the staff can be seen as a metaphoric strategy which obliquely allows her to resist the threatening systems of control through which her dependencies might be cared for.

Annie was never admitted to Highfield House and remained uneasily peripheral to both the outside world and the institution itself. To her, permanent residence in 'care' represented a yielding of control which prefigured an ultimate loss of personal control at

death. Yet in remaining uncared for Annie's position in the wider society became increasingly tenuous. As she was aware, her growing physical deterioration made her prominent, 'an exhibition', whenever she went out into the town.

While both Winnie and Annie represented challenges to the controlling care of institution, Annie's more effective attempts were made at greater personal cost. In resisting control she remained uncared for. Uncared for she was vulnerable to suffering which might get rapidly out of control. Already under control Winnie's gentler challenge provoked care in the form of figurative violence - the clenched fist. Remaining at the periphery of the system, an involuntary embodiment of uncontrolled physical frailty, Annie provoked literal if oblique verbal violence from the staff. With respect to the institution much of Annie's remaining power resided in her weakening body, one which lay disturbingly beyond the limits of curative medical techniques and could now only be cared for.

1.3 Power Holders.

As noted, a secular state-run institution such as Highfield House is a context where care is offered within and through structured channels of control. It is given in the form of individual acts of kindness or humour. In the person of Mrs Chapman, the Matron of Highfield House, the juxtaposition of caring individuality and membership of a controlling category is marked. Structurally powerful she manipulates the relationship between these two possibilities in order to exercise control. Structurally powerless residents struggle to retain individual control by resisting institutional categorisation - whilst at the same time avoiding the prominence accorded to disordered and deteriorating individuals and, additionally, the final individualizing of death.

My own 'admission' to Highfield House was the point at which my contact with Mrs Chapman was most extensive. The following extracts from fieldnotes illustrate the powerful way in which she is able to move between the roles of 'Matron' and 'the Matron', from a caring individual to the representative of a controlling category:

> Mrs Chapman seemed very open to my interests and spoke of **"really getting to know the residents"** - working with the care assistants was the only way. I would get attached to the residents by bathing, dressing and caring for them - they would talk to me, tell me all their secrets, all their problems. I could also sit with the staff and find out how things were for them. She said she had a very good staff - it would be strange for me at first but it was the only way. She said I would really enjoy working in the home. (Highfield House fieldnotes. Day one).

> Mrs Chapman eventually appeared in blue mules and a peasant- style blue crimplene dress. She spoke to me in her office in a self-revealing, forceful and yet chatty style. She showed a very real love and fascination for old people. She gave me her views on the lack of discipline in young people, on the battles she'd had with families, on character in the young - she said she could tell within a month if a Job Creation youngster would make something of their lives. In her story-telling she stared at me, re-enacting the aggressive parts she'd taken before with me as her new victim. Yet she threw in confidences about the state of her health, her need to unwind, her sensation of coldness despite the sun. She told anecdote after anecdote about her residents. One old lady had refused an operation, wanting to be left to die. Mrs Chapman had taken her in a wheel-chair on a tour of the home on Christmas Eve and had promised her a visit to **"somewhere special"** (Mrs Chapman's flat in the home). There they had drunk sherry together - got tipsy - and old Molly was happy. She died in January after only one day in bed.
>
> There was the story of a fight with a resident's daughter-in-law. Mrs Chapman had suggested that residents have only one plant in their rooms and have the rest out in the public areas of the home (owing to rotting of the window sills). The daughter-in-law had put in a complaint to County

Hall without telling Mrs Chapman. Mrs Chapman had her in her office, told her off, and refused to allow her to visit the old man in his bedroom again. A similar battle had occurred over a china cabinet and Mrs Chapman had threatened to put it out into the grounds.

Betty May, a resident, was meanwhile hovering at the office door and Mrs Chapman got her in and, with much hugging, hand-holding, touching of clothes and hair, she joked with Betty May, refusing to seriously discuss ninety-four year old Betty's complaints, keeping her face very close to Betty's the whole time. Mrs Chapman had made much of hygiene and cleanliness, talking of the dirty marks on residents' clothes as they passed her door. She said old people had dirty habits and had to be encouraged to be clean and tidy. She also complained about poor treatment in the local hospital, residents returning from there with bedsores etc. She felt that standards had declined seriously in the hospital -she had even seen a ward sister wearing Jesus sandals. Mrs Chapman had been a nurse herself at one time. She said that she had done every job there was in the home - right down to cleaning out the toilets. (Highfield House fieldnotes. Day two).

These two encounters with Mrs Chapman reveal almost every dimension of her power. What I was offered on first admission promised to fulfill all my hopes for extensive access to what went on in the home. What is significant is the prescriptive manner of the telling - how I was going to feel about residents; how they were going to respond to me; the nature of the strangeness and of the enjoyment I was going to experience.

On second entry Mrs Chapman met me at her desk, her official, powerful position within the home, whilst dressed in the most informal manner. I was made to wait and then informed of her views on discipline in young people, dirty habits in old people and assertiveness in middle-aged people - her residents' relatives. Anecdotal material lends substance to what is essentially a declaration of her intent and suggests that she speaks from a great breadth of personal experience. Similarly, the verbal declaration I was given was complemented by a

performance or demonstration of how to control and how to care - as in her management of Betty May's complaints. Finally, she fragments her entire conversation with confidences and asides about current difficulties in her personal state of health and well-being.

Barthes in 'The Blue Blood Cruse' shows how press revelations of the 'human' face of royalty underscore their elitist status.

> ...if one is amused by a contradiction, it is because one supposes its terms to be very far apart. In other words, kings have a superhuman essence, and when they temporarily borrow certain forms of democratic life, it can only be through an incarnation which goes against nature, made possible through condescension alone. To flaunt the fact that kings are capable of prosaic actions is to recognize that this status is no more natural to them than angelism to common mortals, it is to acknowledge that the king is still king by divine right. (1973:32-33)

In her role as 'the Matron', Mrs Chapman could reduce a domestic to an entire lunch-time's weeping and could inspire care staff to pull me bodily out of her sight when I smoked a visible but illicit cigarette in the staff room. I would argue that just as the 'prosaic actions' of kings underscores their divinity, so the human weaknesses revealed by Mrs Chapman rendered her authority yet more impenetrable. One further example from fieldnotes illustrates the approach which she deployed so frequently.On this occasion she was speaking to me in the foyer after approximately two months fieldwork.

> Matron pursued her usual themes of how **"canny"** the residents were and what a good staff she has - she relies on their close contact with residents to give her feed-back on how everyone is doing. She went on to talk about her own state, how she wasn't feeling herself - she thought she was going through the change - her hormones were unbalanced and she takes a long time to pull herself round in the mornings. She feels she has the support of her staff - she can **"bawl them out"** and they still

> support her. She says she tries to be understanding with the residents when they are being difficult - they do have a lot of problems. She said that a resident's house was up for sale and the contents scattered just recently - the resident had had all her parent's posessions in the house and was very emotional about it afterwards. Matron said she felt really upset for her and went up and had a good cry about it in the evening. This chat - so sudden and so compelling - seems a classic example of a particular kind of exercise of power. The coolness at other times is suddenly dispelled and a sense of a 'special' intimacy is given as a lot of personal information is revealed.

Throughout my entire period of fieldwork Mrs Chapman continued to move back and forth between the roles of 'Matron' and 'the Matron'. Seemingly aloof and inaccessible when in her office she would go and come at random within the rigidly structured times and spaces of bed-sitting rooms, dining-room and kitchen. Her starched, all-white uniform dress contrasted with care staffs' more informal blue-checked dresses or overalls. It also contrasted strongly with her appearances in elegant and often close-fitting dresses worn together with mules or carpet slippers. Again her choice of clothing, like her appearance, was unpredictable. Furthermore, in its apparently very idiosyncratic mix of official, formal and informal categories of style, the Matron's dress accurately reflects her ambiguous position within the home. As she moves within the home - her domestic and her work place - she embodies not only the informal, domestic task of caring but also the official, hierarchized processes of control. Unlike care staff who came into the home to work according to a rigid rota of shifts, Mrs Chapman, like the residents, lived in the home and her on and off duty periods were not easily distinguishable. By contrast my own less than rigid comings and goings were often a topic of conversation with staff. While my working presence represented nothing more than an extra, often superfluous, pair of hands, any deviations I made from a roughly formulated personal timetable always invited enquiry.

In summary the Matron is so located as to exercise indirect yet maximal control over the processes of ageing/dying both through her access to medical resources and through her control of care staff continuously involved in the management of these processes. Through the personal style of Mrs Chapman the authority vested in the role of 'Matron' is articulated in particular ways. The tense ambiguous relationship between caring and controlling which care staff experience is clarified and indeed made use of by Mrs Chapman in her continuous and unpredictable transition between a caring and a scaring mode of behaviour, from the role 'Matron' to the other role of 'the Matron'.

2 IMPLICIT STRUCTURES OF CONTROL: STRATHCARRON'S REVEALING MASQUERADE

As shown previously,[7] it is the social, spatial and conceptual boundary of the residential home which is critical to the nature of its entire structure. In the urgent task of maintaining an evercrumbling separation between 'life' and 'death' the peripheral figure of the Matron is central to the management of power.

By contrast the hospice is oriented towards transcending the boundary between life and death. Indeed the creation of a 'life'/'death' continuum is one of its primary, underlying aims. In that the separation of 'life' and 'death' continues to prevail within the wider society, the transcending or muting of established categories/boundaries requires that they become a particular focus for attention. Whereas the rigidly defined boundaries of Highfield House are intensified representations of pre-existing and therefore 'natural' cultural frameworks, boundaries emerging within the hospice are subject to consciously formulated transformative cultural strategies. These boundaries lie in the areas of gender, class, religious affiliation, hospice/community, present/the hereafter. Through forms of

symbolic mastery such as those presented below, a sense of movement or flow is established at all levels and in every area, so incorporating and reintegrating each aspect of the past, present and future of the dying individual.

The following fieldmaterial demonstrates the implementation of such strategies. Closer analysis indicates its additional resonance - on further, less apparent levels. Individuals, such as Annie Crosby, who contemplate a life 'in care' at Highfield House, will receive that care through implicit, structured channels of control. Individuals diagnosed as terminally ill who are encountering death in Strathcarron Hospice, are given an explicit offer - of care and of control. That control is not, however, an aspect an asymetrical distribution of power as in the social hierarchy of Highfield House. Rather, it is one aspect selected from the controlling power of medical technology - that is to say, pain control. Technological control and Christian care are thus drawn upon simultaneously but in careful distinction from one another. What is revealed however within the fieldmaterial which follows is that a hospice event can take the form of an implicit play upon its professional, religious and gender divisions - and the dynamics of power which link them. When Strathcarron's 'caring team' let their hair down, their hidden, hierarchical relationships with one another become evident in a humourously overdramatised performance. Thus an example has been selected which reveals the complexities and ambiguities of managing a caring team, who offer unconditional support to the patient as a whole being, within a wider society where care and control are more commonly encountered in often deliberately blurred conjunction.

A slide show offered to hospice patients who come into and out of the building for day-care is an occasion which illustrates the emergence, and the masking, of hierarchized structures of power among Strathcarron's 'caring team'. It was staged in one of the hospice wards, thereby providing entertainment for the bedbound -

and a gentle introduction to the context of dying for the more fit. Its content is a figurative representation of a team of doctors, nurses, administrators and domestic staff who, it might appear, care for dying people outside more traditional, hierarchical structures of power.

Mary, the day-care sister, erected the screen, curtains were drawn and the unfocussed slide show began. The material for the August morning's event was drawn from two earlier occasions, a Burns Night hotel supper and a Christmas-time hospice party. Slides showed staff in unfamiliar evening-wear, elaborate, formal and glamourous, clustered together at candle-lit tables. Further shots showed staff in other, more bizarre guises. Santa, the Pied Piper, two grotesquely fleshly fairies, Worzel Gummidge, a giant gangling baby, a St.Trinians' schoolgirl and Buttons were all seen to cavort in the same, familiar setting as the morning's slide-show.

In this small institution where patients of all categories share a single day-care room, the staff - doctors, domestics, nurses and volunteers - also work together in close proximity. Address is invariably by Christian name and a joking, caring intimacy prevails. Flowery collars and aprons provide an attractive relief to the clinical white of nurses' uniforms. In their varying colours they also distinguish rank or category. Although such distinctions reveal a division of labour, the concept of a 'caring team' predominates. The informal scattering of furniture in the one staff lounge and dining-room is seen to mitigate against an hierarchical distribution of status. Nonetheless hints emerge of an implicit structure, entirely in keeping with the hierarchical system of social class and gender division in the wider society. In what one of the doctors described as the **"high nonsense"** of Christmas-time, implicit systems and hidden conflicts come to light.

For example, Molly, in a blue dress with white daisy-chain collar, is Matron. Tall, slim and girlish, she possesses a soft-voiced, intelligent sensitivity, very much in contrast with images of large-bosomed, officious Matrons. When nurses and volunteers adopted 'Molly' as their term of address for her, the Matron chose to stress her position of dominance in the 'caring team' and insisted on the use of her title in the public spaces of the hospice. Molly of the private morning meetings with doctors, home-care sisters and social worker, moves out into the public space of nursing and domestic staff as 'the Matron'.

Similarly an implicit social organisation of space reveals the continuous emergence of the social hierarchies of the outside world. Thus the private spaces of the nursing and domestic staff are a bathroom and a backstep, away at the west end of the building, tucked behind the white board fence which conceals a revolving washing-line and the external entry to the mortuary. Snatched smoking and illicit snacking on hospice food takes place here. On her break from hoovering and washing-up, Morag, a domestic, squatted on the backstep and observed:

> **"Its like Upstairs Downstairs. The elite upstairs in the lounge and us down here."**

An explicit welcome awaits her in the staff lounge upstairs at the east end of the building. Like all domestic staff, she accepts this welcome only occasionally and with diffidence, preferring a hard-backed chair away behind the upholstered furniture in the centre of the room. Her grudging deference to an 'elite' finds an echo in the very respectful deference of volunteers to medical staff. Voluntary receptionists at the stairwell switchboard swop schoolgirl shock/horror stories of cutting off the medical director's phone calls and give hand-over-mouth accounts of his aggrieved appearances on the balcony above their heads.

Conformity to such a distribution of status remains implicit as an aspect of the 'staff' role within the hospice. Made visible only in the use of private spaces or through transgression, the hierarchical structuring of power is scarcely perceptible in the gentle banter which pervades a public space such as the reception area.

Conformity to the doctrines of Christianity is another somewhat ambiguous aspect of the 'staff' role within the hospice. Though the institution grew primarily out of five years work by members of a Baptist church in Stirling, care is taken not to impose its Christian foundation inappropriately among patients. There is little by way of prominent Christian iconography in the public spaces of the building and the short morning service, held in the day-care room before visitors arrive, is attended voluntarily by staff. Patients in the wards can listen in on headsets but only if they choose to do so. Like the hierarchical structuring of status, the assumption of a commitment to Christian belief among staff remains an implicit aspect of relationships within the hospice. Margaret Owen, the day-care sister, is a late-comer to the hospice. Though her relationships with other staff are close and easy, she talked in private of her reservations about the predominance of a Christian **"emphasis"** in many areas of hospice life. As a non-Christian she feels the lack of scope for expressing adherence to other belief systems.

As an additional undercurrent to issues of professional/social status and religious affiliation, there also prevails the asymetric distribution of power and status between men and women which is common to the wider society. Those who fill the roles of doctor, administrator, Chaplain and chef are men. With few exceptions, those filling the roles of Matron, social worker, home- and day-care sister, nurse, clerical worker, domestic and volunteer are all women. While single women in their thirties or early forties fill the higher status positions of Matron, social

worker and day-care sister, it is married women with children who predominate. The skills they have acquired in child-care and domestic management are put to use in their role as the institution's 'Front Women'. Downstairs, in wards and reception, their unassuming, empathetic patience and warmth prefaces the more high-powered medical and administrative resources of the male staff above.

Issues and conflicts of this kind remain carefully submerged within the much-discussed and highly-valued concept of the 'caring team'.

"They're a great bunch"

said the Administrator as he threw a pebble up against the lounge window where most staff take lunch-time coffee. The 'high nonsense' of occasions such as the Burns Night supper and Christmas party is seen as an explicit representation of an egalitarian community. A doctor described how a whole range of individuals have **"gelled"** in this community where humour **"bubbles up all the time"** and all must be prepared to **"have their leg pulled"**.

The occasion of the slide-show was an invitation for patients whose current fear and suffering are managed through the skills of the caring team, to laugh for a second time at the antics of a staff upon whom they depend. What was exposed to them as a titillating behind-the-scenes glimpse of the staff at play, can be seen as a representation of a quite different kind.

In making their choices of costume, staff drew on the associations of a range of stock characters in a larger-than-life re-creation of their implicit relationships with one another. That David Lane, the medical director, should play Santa would seem to go without saying. He is both the head of the medical team whose skills are accorded greatest status, and also the

primary worker in establishing the hospice. Cloaked and bearded in the guise of Santa, this determined but awkwardly shy man moved into a prominent, central space as the airborne deliverer of magical goods from another realm. In the depths of winter, close to the end of the year, he is the Father who brings the child its longed-for toy and condemns any bad behaviour.

Many aspects of David Lane's relationship with those who come to die in the hospice find overt expression in the role of Santa. These include his benign and fatherly power to discuss, decide and to dispense drugs on their behalf; the respect and gratitude which patients feel towards him; the implicit moral and religious framework through which he advises and orders a patient's care. In comparison with nurses he is relatively elusive as far as patients are concerned. In private and at times in public he is ready to offer not only a drug regime and medical care but also criticisms and warnings. Always addressed as 'Dr Lane', his presence is sought after and his advice heeded. Slightly incredulous laughter was provoked by one very ill and confused patient who summoned him by the title 'Uncle David'.

Santa entered the party in the wake of Molly, the Matron, dressed as the Pied Piper. Again the associations of this piebald, villainous hero are expressive. Molly/Matron manages an ambiguous role as a sweet-voiced, daisy-chained carer who is also known to give 'rows' to all nursing and domestic staff for minor transgressions such as working bare-legged.

Two other characters, much to the fore in all slides, were a pair of fairies. They were vast in black stockings, garish makeup and camisole tops stretched over bulging breasts and bellys. Unlike David Lane, physically concealed behind beard and cloak, Graham Bell and Michael Younger, doctor and administrator, were revealed very much in the flesh. Their stalwart masculinity was thus heavily emphasised in this earthily sexual parody of ethereal, whimsical feminine forms.

Female members of staff were seen in guises which reflected a lower status or less central position within the implicit hierarchy of the hospice. Bridget, the home-care sister, plays an independent and very responsible role in her more solitary work in the community. Nonetheless in 'team' meetings she is deferent to the medical staff, pursuing her own ends through persuasion. Though she too inverted her own gender, it was as Buttons, the low-status boy page. Moira, the very tall and insightful 'downstairs' domestic, entered as the giant helpless baby with dummy and nappy, crying for her `Mammy' throughout the party. Margaret Owen, the non-Christian newcomer, ever slightly at odds with the peace and order of the hospice, appeared as Worzel Gummidge, the audacious outsider, the straw man-of-the-fields who wreaks havoc by moving into the flesh-and-blood world of human beings. Lorraine, Dr Lane's secretary, unwillingly childless, in her thirties and elaborately made-up, appeared as the illicitly sexual child, the St. Trinians' schoolgirl.

Thus in Christmas-time fancy dress the dissonant presence of hierarchichal structures of power is made evident in an over-determined, heavily-dramatised form - then to be further transformed into a summer morning's diversion for patients. In the very visible 'letting down of hair' patients are exposed to yet one more metaphoric representation of the transcending of category. And in their choice of disguise staff implicitly re-affirm those structures through which a necessary sense of cultural continuity between the hospice and its wider social context is maintained.

The revealing masquerade can be seen as a powerful performance within which the tensions between care/equality and control/hierarchy are both heightened and transcended. Separating boundaries are both dramatically overstated and also humourously transcended or subverted.

3 SUMMARY

The four examples from fieldmaterial - Winnie Elliott, Annie Crosby, Mrs Chapman, the Slide Show, presented in this chapter are alike in their densely patterned character, one which encompasses both the evocation and the disguise of the conflicting issues, care and control. Those empowered to care for both the weakening bodies and the needy selves of ageing and dying people find themselves in an uneasy encounter with the powerful evidence of physical deterioration and decay, conditions entirely resistant to medical control.

The following chapters (10 and 11) bring together the two areas of tension, 'personhood' and 'individuality', care and control. Discussion will show how these tensions come together and are managed within the experience of those more extensively and intimately involved 'insiders', the care assistants, aids and residents of Highfield House - and the patients of Strathcarron Hospice. For all caring staff self control and the control of others are complex and challenging issues. In both the residential home and the hospice controlled caring and careful control must be continuously maintained - lest they be transformed into uncontrolled, unmanageable caring or careless, callous control.

NOTES

1. See Chapter Three, pages 82-86.

2. See Chapter Three, pages 72-74.

3. The Gospel of St John, 3.16.

4. The Gospel of St John, 10.1f.

5. The Gospel of St Luke, 10.30f.

6. The Gospel of St Luke, 15.11f.

7. See Chapter Six, pages 164-168.

CHAPTER TEN

BATHROOMS, BEDROOMS AND CORRIDORS: PASSAGE THROUGH HIGHFIELD HOUSE

In Highfield House ageing is managed through a careful control of boundaries. The power located at the home's periphery and in the person of the Matron has been shown to be critical to the maintenance of temporal, spatial and conceptual boundaries throughout the institution.[1] The generative principle reiterated in each and every division or separation, is a particular life/death boundary which currently pervades the home's wider social context.

From this theoretical base discussion now moves closer to the personal experience of care staff and residents, the insiders of Highfield House. For care staff the continuous process of creating and re-creating an experience of controlled stasis or timelessness predominates. The ambiguous and fluid biological conditions of ageing and dying do not lend themselves readily to any rigid and stable classificatory system. Furthermore those who age within this context, the residents themselves, can be seen to seek consistently for continuities of a kind which provide meaning and coherence within their past, present and future lives. Within the confines of the home's controlling boundaries their search is an often idiosyncratic and highly personal undertaking, one which can be compared with the institutional, ritual, creation of continuity and flow within the hospice.

1 HUMBLE SERVANTS

While the Matron of Highfield House is in control of both literal and figurative reality within the home, her care staff occupy a unique position in relation to her authority. The exercise of

authority in the home is unlike that to be found in institutions such as those devoted to accumulating profit. In the latter the aim of the institution is one which brings most reward to its more powerful members. As a result their purpose and authority is sometimes subverted by less powerful members, particularly if they lack the incentive of profit or promotion. By contrast the underlying purpose of the residential home is the management of physical deterioration and dying. The authority vested in the Matron is a crucial reference point in the mangement of these processes.

When the Matron expressed her authority in a very direct fashion, she would be described by staff as:

> **"on the warpath"**

or

> **"having a purge"**

Any perceived injustices of hers towards staff met with little resistance from them. As a care assistant in her fifties said:

> **"You feel like school girls, being told off. You feel like arguing your case - but I think its better to just say nothing"**

Thus staff colluded in assuming the status of schoolgirls. By attributing ultimate responsibility for what went on to the Matron they created for themselves an outside source of authority in their management of residents. When the Matron chose to scold a young domestic worker publicly in the kitchen, staff comforted the sobbing girl by telling her to try and accept what had happened. Thus Norman, the porter/handyman, drinking tea and eating sandwiches, said:

"Calm yourself, Lorraine - it'll blow over man - don't think about it - put it out of your mind"

Susan, the cook, similarly said:

"I've had it - from the Matron and the residents. Don't let it get to you. You can't do nothing about it"

Though the Matron remained physically within her office for a large part of the day, her name was in constant use throughout the home in persuading residents to comply with staff's wishes. Such was the power ascribed to her presence within the home that Mary, the assistant Matron, would insist that the residents all developed problems as soon as the Matron was seen to disappear out of the main door. Jokingly Mary told the Matron to put a sack over her head when she went out, so retaining the powerful illusion of her presence within the home.

Care staff's willing subservience to the Matron's authority was compounded by their very marked lack of information concerning events other than their own immediate tasks. This, together with a lack of any medical knowledge concerning individual residents, effectively absolved staff from ultimate responsibility for what went on. When I declared my concern over causing pain to a resident in sickbay while helping her to sit up and take food, the care assistant working with me replied:

"Well you can only do your best for them you know"

Willingly debarred from ultimate authority, care staff create for themselves a circumscribed scope for power within which they can only do their best.

Thus in the particular circumstances of the residential home the authority vested in the Matron by her employers, the Local Authority, is rarely challenged by staff. By chance the shoes I wore initially gave my footsteps the same sound as the Matron's. Care staff's faces, turned towards me as I entered the staff room, revealed the awe in which she was held. I quickly abandoned these unsuitable thin-soled shoes as, unlike the Matron fixed and at a distance in her office, my assumed role as care aid involved the endless and exhausting movement through the building which brings exposure to the physical evidence of deterioration and decay.

1.1 Keeping them going.

The duties of care staff are two-fold. It is their responsibility to ensure that the bodies, the beds and the clothing of all residents are clean; that a rigid regime of meal-times and bed-times is maintained and that a minimum of emotional and physical distress is manifested among their charges. In thirty-seven identical single and double bed-sitting rooms, in lounges, bathrooms and dining-room, continuous adherence to this task is the overt pre-occupation of all care staff. Two sickbays and an unobtrusive mortuary are the only spaces which attest to their more covert task of supervising the process of dying and the event of death. It is required that both tasks will be pursued simultaneously, that the slow deterioration of members of an ambiguous social category will be managed within the virtually undifferentiated spaces of an institution set apart amidst lawned gardens at the periphery of the city. In such a context the conceptual categories 'life' and 'death' intrude upon one another continuously. A constant vigilance is necessary to the maintenance of distinctions and separations.

One strategy through which such boundaries are continuously maintained is the cultural transformation of institutional space. Admission to institutional space is not made available to

individuals whose death is apparently imminent. Bedfast, incontinent or dementing people are excluded. Thus the greater part of the home, the upstairs bedrooms, the lounges and the small scattered tables of the dining-room, is maintained ostensibly as accommodation for the 'living', for mobile, continent residents still able to wash and feed themselves.

Nonetheless doubts and ambiguities as to the nature of their social status have already been introduced through the inherent separations of the admissions procedure. The new resident has therefore not only experienced an implied social death but will also, at some point, begin to display some of the conditions which preclude entry and portend imminent death. In such a situation care staff are continuously involved in making a subtle and gradual spatial separation between those fitted to remain with the areas which can be described as 'living' accomodation, and those whose membership of even this ambiguous category is increasingly open to doubt.

One by one, failing residents are moved downstairs to bedrooms on what is known among staff as the 'frail' corridor, within a few yards of the two sick bays where dying people are cared for. Similarly such residents find their armchair in one of the lounges supplanted by a seat in the open alcove at the beginning of the 'frail' corridor. Increasing immobility and the need for regular 'toileting' rapidly curtail their movement outside those areas of the home associated with illness and with death. It is in this way that care staff are able to create a somewhat precarious distance or spatial boundary between 'fit' and 'frail' residents.

The time and place of death itself nonetheless remains unpredictable and at any moment this boundary can become particularly fragile. Within the confines of the institution, its random occurrence is always an implicit possibility. Throughout each night care staff check the breathing of all

sleeping residents at hourly intervals. Taking day-time naps on her bed, a female resident whose breathing was very shallow shocked more than one care assistant by her resemblance to a corpse.

Should one of the 'fitter' residents show a sudden deterioration, care will be taken to move them downstairs to one of the sick bays. Failure to note the signs of imminent death can involve staff in the unorthodox removal of a corpse from upstairs 'living' accommodation in a wheelchair. The small lift is intended for the living only and cannot accommodate a stretcher-borne body. Nonetheless sudden deaths can and do occur among the category of 'fit' resident and staff express strong dislike of what they describe as the **"degrading"** removal of a seated corpse, the improper fusion of the two categories of the living and the dead.

Though properly managed deaths take place in the sickbay, ambiguities are still encountered in that the corpse must then pass through the space of the living on its journey to the mortuary. An impromptu transformation of this space is effected through the deliberate closure of lounge and bedroom doors en route and the strategic positioning of staff members between the 'frail' who doze in the open alcove and the passing corpse.

In the mortuary, at the periphery of the home, the distinction between the living and the dead remains at issue. The Deputy Matron, when asked if a recently deceased resident had been coffined, misheard the word 'coffined' and interpreted the question as:

"Has Mrs Atkinson been coughing ?"

Only later was she able to laugh about the horror which this mistake had aroused in her. Similarly, a member of the domestic staff suggested that a particular corpse was not in the mortuary

when she cleaned it and jokes were made about the deceased popping out to the toilet. Night staff were horrified to discover the morgue doors flapping open in the wind at dawn one day. Mistakenly thinking a corpse was in the morgue at the time, they feared that both corpse and trolley had rolled out into the courtyard and away down the drive.

Thus the allocation or transformation of limited institutional space can be seen as a cultural strategy through which the conceptual categories of the wider society may be given expression. The dilemmas introduced by setting elderly individuals apart in the 'living'/'dying' space of the institution may in part be managed through physical manoeuvring of this kind.

Another important strategy in the creation of separations and distances is the use of linguistic transformations. Thus the manipulation of space is complemented by forms of verbal manoeuvring, or metaphoric strategies, through which the more intractable ambiguities of the system are distanced or transformed. For example, the search for a refined medical framing of the biological process of dying which pervades the wider society finds parallels in the institutional setting. Though a precise medical understanding of residents' physical condition is lacking, care staff nevertheless make implicit distinctions between the categories of 'fit' and 'frail' residents through a subtle and often humourous use of language. Two examples illustrate the process through which membership of one category or the other is imposed upon residents:

> (1) Alice Dixon was made to come down from her upstairs bedroom for breakfast when she was feeling unwell. Her subsequent attack of faintness was viewed with angry scepticism by staff. They interpreted it as **"dramatic"**, an **"Oscar-winning performance"**, mimicing her **"ohhs"** and **"ahhs"** and the way she had clasped her hands over her heart. In words and in actions they metaphorically transformed Alice's physical distress into a

theatrical performance, thereby refuting evidence of her possible transition to the category 'frail' resident and affirming her membership of the category 'fit' resident. The fragile, arbitrary nature of such a distinction was later affirmed when staff not only allowed Alice to return to bed but also requested Matron look in on her, saying,

> **"We don't want a dead body on our hands"**

(2) Mabel Carstairs, a resident in her mid nineties, refused outright to come downstairs for breakfast one morning. Huddled deep beneath her bedclothes, she spoke bitterly to me of her sleepless night, her desire for death and her unmet need for sympathy and understanding from staff. Coming out of her room, I was asked by a care assistant:

> **"Oh, is she still playing the dying duck!"**

As in the previous example, a resident's distress is interpreted by staff as play- acting and her status as a 'fit' resident is affirmed. In her choice of metaphor,'dying duck', the care assistant both reiterates the notion of a theatrical performance and also denigrates its quality. That Alice might aspire to death in the role of a 'dying swan' is both suggested and mocked in the choice of 'dying duck'.

Distinctions between an inability as opposed to an unwillingness on the part of the resident to remain mobile are not easily made or maintained by care staff. Earlier examples showed that in a context such as the residential home a living horizontal body can be powerfully suggestive of a corpse. Doctors visiting sick residents often imply that one state can quickly lead to the next when they assert the medical dangers to the lungs of a horizontal position. For example, after a fall a resident was prescribed a week's bedrest by medical staff at the local hospital. Contrary advice from the resident's GP (that bedrest would endanger her lungs) lead to a compromise on the part of care staff. The resident was isolated in sick bay for a week - but propped up uncomfortably on pillows in a wheelchair.

The suggestive sight of a horizontal body is more than matched by the ominous presence and smell of a resident's urine and faeces. Asking for advice about the handling of 'accidents' when I began fieldwork, I was always told, **"You avoid them"**. Incontinence must nonetheless be managed and staff deflect its threatening power by inverting the name of that which they are required to handle. By taking one of the more potent and offensive names by which faeces are known - 'shit' - and reversing the order of the letters to create the word 'tish', the full force of the event is both acknowledged and subverted. 'Tish' is used, either as a noun or a suitably regular verb, by the staff as a group and requires no ammendment when entered into the Report Book in the staff room. Official acknowledgement of its force is given in the form of an additional 30p pay for every day on which a staff member has handled it. In order to receive this money, staff are required to enter the letter 'F' for foul linen in the appropriate box on a time sheet. Within the home, staff's use of the word 'tish' represents both an acknowledgement and an inversion of the power of incontinence, a verbal form which corresponds appropriately to the physical act of first handling faeces in order then to remove them. Outside the home the wage clerks receiving time sheets in County Hall are not required to confront the evidence of incontinence and, for their eyes, the prescribed euphemism 'foul linen', aptly makes reference only to that which can be measured in financial terms, the supply and laundering of linen.

If those who have what are referred to as 'accidents' do not display signs which presage imminent death, staff are able to deflect the impact of their occasional double incontinence by creating metaphoric shifts in the social status of incontinent people. By figuratively attributing a lazy disposition or a child-like status to the residents, the literal implications of lost bowel control are veiled. For example, when a care assistant discovered the draw sheet of one of the fitter

residents was badly streaked with the stain of faeces, she turned it over rather than changing it. In doing so she said:

> **"If he can't be bothered to wipe his arse then he'll just have to put up with it. It's just laziness. It's not as if he's incontinent."**

To soften the harshness with which she had refuted the evidence of deterioration she added:

> **"I get nasty after I've been on for eight days"**

And indeed she had worked an eight hour shift on eight successive days.

The interpretation of incontinence as a social misdemeanour rather than as an aspect of physical deterioration allows those who are required to confront it in order to remove it, to figuratively diffuse the power of an act which signals an approaching death. Another resident, Ethel Brandon, who had retained the ability to walk, to converse and to feed herself, suffered from fairly regular bouts of double incontinence. Being cleaned after an 'accident' she was told by the care assistant concerned:

> **"You've dirtied your knickers, you naughty girl. You said you hadn't. You should get up in time. You must know when you want to go to the toilet. We all do."**

By interpreting Ethel's incontinence as a childish accident, care staff are able to distance themselves from the disturbing literal evidence of physical deterioration which they are required to handle. Whilst the incontinence of young children may be frustrating, its implications are far less threatening than the incontinence of elderly people. Like the verbal inversion and transformation of the potent 'shit' into the essentially

meaningless and amusing 'tish', old age incontinence is reinterpreted as childish wilfulness.

Examples of fieldmaterial drawn from among the residents of the 'frail' corridor show that in this contrasting location staff are ready to affirm evidence of a deathly status. In opposition to the 'dying ducks' up above, these residents are described as:

"just like a little corpse"
"just a little skeleton"

While staff interpret the waning mobility or incontinence of 'fitter' residents as playacting or childish wilfulness, they perceive aspects of the physical condition of the 'frail' as signs of imminent death. Two examples illustrate this:

(1) In March 1981 a 'frail' resident, Mrs Watson, was said to have had a 'collapse'. Lacking in medical knowledge, staff nonetheless made grim note of the 'signs' of imminent death, sunken eyes, rattling breath and a bluish tinge to her nose. Feeling her forehead they exchanged knowing looks, saying:

"Poor little soul. Two o'clock will test her"

In fact Mrs Watson remained wearily alive for another three months, despite staff's repeated assertions that she was:

"on her way out"
"likely to pop off soon"

(2) In February 1981 a care assistant announced that there was little hope for Molly West, a 'frail' resident who had spent several months in sick bay.

"Well its a blessing really. She's just a vegetable. Poor little soul"

> Three weeks passed, the care assistant maintaining that **"it could be any time now"**. In June 1981 Molly was reinstalled at her table by the dining-room service hatch. She lived on in the home for almost another two years.

These examples illustrate an implicit social process of categorisation through which distinctions are introduced within the slow and uneven deterioration of the members of an ambiguous social category. It is this complex, unpredictable process of decline which predominates within the home, among the 'fit' who ail and the 'frail' who linger. In asserting the liveliness of members of one category and anticipating the demise of members of the other, staff maintain meanings and distinctions associated with the conceptual categories 'life' and 'death'which prevail within the wider society. One last example, a brief case study, shows how uneven the processes of physical deterioration can be among very elderly people. It describes staff's attempts to overcome some of the ambiguities raised in the case of one of the elderly women living in the home. Repeatedly they manoeuvred her back and forth between the two categories, 'fit' and 'frail' resident:

> Alice Hepple, a small, thin and rather confused resident, was admitted to care when her dependency proved too overwhelming for her daughter to manage. Alice was nonetheless communicative, mobile and well able to feed and wash herself. Repeatedly staff led Alice into the lounges implicitly reserved for 'fit' residents. They offered her a walking frame rather than their supporting arms, saying:
>
> > **"Go on Alice. Walk with the ladies !"**
>
> Alice, however, failed to take up a place among 'the ladies'. Conspicuous as she tottered aimlessly in the corridors, Alice rendered herself a highly ambiguous individual to the eyes of staff. Though she continued to walk, eat and speak, it was with increasing difficulty and reluctance. Always in the wrong place at the wrong time, Alice was confused and slow-moving. Staff's ineffectual

> attempts to impose membership of the category 'fit' resident were eventually abandoned and within six weeks of her admission staff led Alice to a seat in the 'frail' alcove and a new dining-place beside the service hatch. No longer urged by staff to conform to the behaviour required of 'the ladies', Alice was described at this point as looking **"just like a little corpse"** when she slept. Like Mrs Watson and Molly West (examples 1 and 2) Alice nonetheless failed to deteriorate or **"pop off"** as anticipated. Living on for another four months, she regained speech, appetite and mobility, this time unaided. The former **"little corpse"** was re-categorised a second time when staff described her as **"coming out of her shell"**. Her re-entry into the category 'fit' resident was confirmed when a voluntary helper offered her a dance one afternoon.

Alice Hepple lived and died in Highfield House in the course of one six month period. Her gradual deterioration proceeded unevenly and was managed by staff through a series of physical and verbal manoeuvres which served implicitly to set Alice firmly to one side or another of a conceptual boundary between 'life' and 'death'.

In summary the position of staff can be seen as essentially paradoxical. As subordinates of the Matron and as members of a society in which death is distanced and disguised, they readily conform to the figurative transformation of the home's purpose which the Matron offers. Yet continuous exposure to the literal evidence of ageing and dying repeatedly subverts their attempts to adhere firmly to this cultural strategy. The following examples reveal the ambiguity of their perceptions:

> (1) Two care assistants, Maureen and Janet, were discussing a conversation between Monica and her husband, Billy, the previous night. In response to Billy's enquiry as to what kind of day she had had, Maureen told him:
>
> **"Hectic. Lifts off and on"**

Billy replied:

> **"By, what a good job you're doing. You must get a lot of satisfaction doing so much good for all those elderly people"**
>
> **"He was being serious ?"** Janet asked.

Maureen nodded and the two women exchanged small,silent smiles. The quietly humourous conspiracy of this wordless exchange reveals their awareness of the figurative nature of a representation of their job which Billy, naively, had interpreted in a literal sense. Nonetheless their awareness remained tacit.

(2) The day after a resident, Charlie Lumsden, had died, another resident, Ethel Robson, asked a care assistant, Kathy, if there was a morgue in the home. Kathy replied:

> **"Yes there is. Its a sort of Chapel of Rest. Its very nice"**

Turning away from Ethel, Kathy gave me the same conspiratorial look, saying nothing.

Just as Kathy transforms the bare room with its slab and small table bearing a cross, candles and flowers, into a Chapel of Rest, so staff, like the Matron, transform the bleak literal meaning of the home. Whilst their faces may betray an awareness of this deception, their perception of ageing/dying as a disordering and potentially uncontrollable process firmly inhibits any explicit acknowledgement of the literal meaning of their role within the home.

2 MARKING TIME

At odds with the pervading cultural separation of the processes of living and dying is the residents' management of their own experience. Staff's implicit commitment to defining and maintaining the two institutional categories of 'fit' and 'frail'

in permanent opposition to one another is a significant aspect of residents' social context of ageing/dying. While care staff address themselves to maintaining a permanent separation between two conceptual categories, residents are involved in somehow making a transition between these two categories, from the independent adulthood of the past to death which lies ahead. It is a process from which staff stand apart and their response is the consistent and coherent set of strategies already described. The responses of residents are however more various. Each one of them is making a solitary, individual journey from entry to exit and the variety of their bodily experience is reflected in the broader range of strategies through which they manage this transition.[2] What residents are seeking to manage therefore is not only their own bodily experience of ageing but also that process as it is being ordered through cultural categories imposed by staff.

Field material which describes such a context reflects an experience of ageing which is not only highly individualistic but is also vulnerable to a set of external, institutional constraints. In seeking to elucidate such material a warning offered by Bourdieu can very usefully be borne in mind. He suggests that:

> ...too much faith in native accounts can lead one to present a mere ideological screen as the norm of practice; too much distrust of them may cause one to neglect the social function of a lie socially devised and encouraged, one of the means agents have of correcting the symbolic effects of strategies imposed by other necessities. (1977:43)

The broad distinction made by Bourdieu between what is said and done by the members of a society in the ordinary course of events, and what is said by those individuals about the doing and the saying of everyday life is relevant here. Terms such as 'norm of practice' and 'ideological screen' refer to specific forms of Bourdieu's two fundamental concepts of cultural

knowledge - those of practical and symbolic mastery.

Practical mastery describes the competence of the individual to pursue their own interests through negotiation and manipulation of the dispositions of their own culture. It is above all a mode of operating which stems from a learned ignorance, from an inherent lack of awareness within the agent as to the generative principles from which their cultural style derives. Though the individual agent makes choices and invents strategies according to the accidents and contingencies of everyday experience, such apparently subjective forms of innovation and adaptation both arise from and serve to re-create the inherent properties of the habitus or cultural milieu of the agent.

Symbolic mastery describes forms of cultural knowledge which are consciously formulated and made explicit by some or all of a society's members. Such formulations can be seen as an attempt to map out the logic or truth according to which the concerns of human life are proceeded with. As Bourdieu suggests, forms of symbolic mastery may frequently serve to impose coherence upon the inconsistencies and ambiguities arising from everyday experience. As reflections, comments and corrections made by some or all members of a society upon its own implicit mode of operation, such diverse forms of cultural knowledge as juridical rules, gnomic poems or native accounts can be said to represent both an ordering and an interpretation of that which is described as practical mastery.

In developing a theory of practice Bourdieu makes two points which are particularly relevant to the ageing process. The first concerns the processes whereby practical mastery is transmitted. The second concerns the means whereby a system of objective knowledge, symbolic mastery, may be used to intercept and influence the practices generated by the principles implicit in practical mastery.

The transmission of practical mastery Bourdieu describes as a process which is realised at a level inaccessible to (self) conscious thought and therefore discourse. Thus he says:

> ...the 'book' from which children learn their vision of the world is read with the body, in and through the movements and displacements which make the space within which they are enacted as much as they are made by it. (1977:90)

Acquired in and through physical movement within culturally ordered space, the generative principles expressed in practical mastery are lodged firmly in the sphere of 'natural', unpremeditated bodily postures, processes and acts, from childhood onwards. In extreme old age the assumed dependability of the body becomes questionable as its functioning ceases to be self-regulating. With the body's often sudden and compelling intrusion into the conscious mind, come changes in the previously unacknowledged possession of practical mastery. Internalised concepts of self, maintained through experience of the self in relation to others and to the environment, are thrown into conscious relief in the face of a changed bodily experience of one's position within a hitherto familiar social setting. Furthermore growing dependency may lead to exposure to the unfamiliar and very cohesive body of objective knowledge expressed and implemented in the provision of residential care for elderly people.

This brings in Bourdieu's second point which is of relevance, concerning the way in which forms of practical mastery are susceptible to consciously formulated systems of objective knowledge. He cites the mechanisms in operation within the total institution as an extreme example of the processes whereby all social institutions, as embodiments of systems of objective knowledge:

> ...extort the essential while seeming to demand the insignificant. (1977:95)

That is to say that the simple yet specific bodily techniques and the new uses of space and time demanded or desired of the inmate by the representatives of the institutional system encapsulate its grounding principles in their entirety. To age and die in residential care is therefore to discover one's unapparent possession of practical mastery subtly transformed into an issue within the conscious mind, whilst at the same time being exposed to a new order, to an unfamiliar body of objective knowledge. Thus abdication of control of one's pension book and one's medicines is one of the tangible bureaucratic trivialities which only implicitly entails the more fundamental but amorphous losses of social role, family position and personal freedom which are associated with institutional care.

In seeking to manage the experience of ageing in residential care residents 'discover' strategies which, I contend, are consistent with the forms of practical mastery implicit within their former cultural milieu. However the novelty of the situation may be so great that, in conjunction with their changed bodily experience, it calls for a range of subjective innovation so apparently unfamiliar as to cast doubt upon the integrity of the individual.

Thus to the forty-five people of varied age, background and physical condition living in Highfield House, institutional care may appear to offer either security or deprivation, companionship or crushing loneliness. Each individual seeks to profit by, to resist or to learn to accept those features of the environment which predominate in terms of their own experience, be they humiliation and restraint or physical comfort and independence.

For example, loss of articulate speech and mobility may result in a resident being subjected to infantilisation. One such resident, being tucked up behind bed bars in preparation for

another night's fitful sleep, was urged by the Matron to settle down, the whole procedure being topped off by a blown kiss from the Matron as she left the room. Though physically constrained and slow to speech, the reluctant sleeper was nonetheless able to express her feelings by offering a stuck-out tongue in exchange for the blown kiss, thereby exploiting for her own ends the infantilisation to which she was being subjected. In so doing she 'discovered' a form of improvisation entirely appropriate to her present situation yet utterly at odds with her earlier life experiences. These included First World War ambulance-driving and a good education perceptible still in the rather refined vowel sounds of her occasional speech.

The world of the insider/resident can thus give the appearance of a context of highly subjective and often bizarre personal choices. Fieldwork reveals their breadth and variation while life-histories indicate the incongruities between past and present status often referred to directly by residents in the observation:

"I never thought I'd come to this"

In summary institutional life represents a move from the private to the public sphere, exposure to unfamiliar experience, and loss of roles, relationships and domestic environments formerly integral to the individual. Though the individual may manage this move through behaviour implicitly grounded in the same generative principles expressed in practical mastery throughout life, exposure to a changed social environment at a time of changing bodily experience may engender responses of a kind which appear incongruous if not contradictory when compared with all that has gone before. Thus the former ambulance driver finds herself in a social environment and a physical condition in which a stuck-out tongue is the simplest and most appropriate means of asserting herself. The shy, the self-sufficient and the independent may respond to dependency and loss of privacy by

silent withdrawal into the manageable minutiae of life within the confines of their bedroom. Those formerly able to assume status through professional role or social class seek to assert that which is no longer taken for granted through use of an insistently demanding and even aggressive personal style.

Bearing in mind the warning offered by Bourdieu, I will return to the central issue of residents' search for continuities which provide meaning and coherence within their past and present lives and their future deaths. As I have argued, this search is located within the constraining asymetrical relationship of power which links residents and care staff.

To follow are examples of residents' assertions that death may be imminent. These oblique, sometimes humourous, statements can be seen as powerful challenges, either to care staff themselves or to the institution as a whole. Within their relationship with staff, residents frequently terminate conversations by explicitly asserting the literal reality of ageing and the imminence of death:

"I'm old - I'm eighty seven"

"What can you expect ... I won't live much longer"
"You can be struck down in a moment"

"You can't turn the clock back"

When a care aid takes early morning tea to a resident his arms are deliberately folded, corpse-fashion on his chest, and he grins at her.

Whilst a 'fit' resident, Nellie, was naked after her bath, she recounted to staff her dream in which she saw her body laid out in its coffin. In preparation she'd already removed her wedding ring, not wishing it to fall into the hands of undertakers. Shocked, eyes-to-heaven glances were exchanged among staff. They were lost for words through which to deflect the residents's

dangerous revelation of the incipient fate of her body.

Seeing staff empty rubbish into plastic bags or sweep remnants of food from the floor onto a shovel, residents joke, saying:

"You can put me in there too"

or

"Sweep me up too. You might as well"

Staff struggle weakly for another joke which can effectively counter and diffuse the power of this embarrassing honesty. Indeed residents' use of rubbish as a metaphor for themselves, though made oblique through humour, nonetheless constitutes a succint and powerful statement about their marginalised social status as well as their fragile physical state. Through the style and the timing of explicit statements about their own mortality these elderly people, like other marginal social categories or groups, are able to make powerful gestures by bringing to the surface that which is muted within the dominant group. Structurally weak they gain stature by reducing the figurative to the literal, thereby drawing attention to the one incontrovertibly human event which remains to them.

Thus while staff are made aware of the literal reality of ageing through repeated physical contact with the bodies of residents, the remarks of residents are additional, unequivocal and, as I have suggested, unanswerable reminders of the imminence of death within the home. Nonetheless institutional time or space is not made available for open discussion of the experiences of aging and dying. McDonald discovers this in this wider society:

> I ... feel shame in talking about my bodily discomfort, aware of the stigma 'old people are always complaining'. But the fact is we spend our lives conveying to others how we feel in our bodies....suddenly in my sixties,

> when my body is doing all kinds of things, sending me all kinds of messages, I am not supposed to talk about it. (1984:109)

So too in Highfield House residents are discouraged in their attempts to open discussion or make enquires. Two examples illustrate this point:

(1) When former cancer sufferer, Maggie Carstairs, was ill in bed, her arm swollen and mottled with red patches, she was visited first by the Matron and then by a care assistant. The Matron set the tone with forceful, joking sympathy:

> **"What are we going to do with you Maggie!"**
>
> **"Throw me in the river !"**
> replied Maggie, laughing.

A care assistant came in soon after, she more subdued and down-to-earth in her manner.

> **"Do you think this is the end ?"**

asked Maggie, not laughing this time. Again denials and jokes were offered by the care assistant in reply - she hoped there would be a really good funeral tea - Albert, Maggie's husband, also a resident, would have to see to it all. She wanted lots of squashy cream cakes.

(2) Ninety-seven year old Hannah Cartwright was one of a small group of elderly people who were transferred precipitately to Highfield House when wiring in another residential home was found to be dangerous. These people were given black plastic bags for their belongings the night before moving and were told of their various destinations only as they were bundled into cars. In Highfield House Hannah ailed and, after a painful, sleepless night, she asked a care assistant:

> **"Haven't you got something for me ?"**
>
> **"Why no Nellie. We wouldn't do that. We wouldn't do that !"**

came the firm and conclusive reply. After her suddenly admission to Highfield House Hannah had been moved from one room to another.

"You've moved again Nellie !"

was the remark of many staff that morning.

"I think this will be the last time"

was Hannah's reply to each one. It drew no further comment.

In these descriptions of two brief interactions between residents and staff four separate and very direct references were made by a resident to their own death:

"Throw me in the river!"
"Do you think this is the end ?"
"Haven't you got something for me"
"I think this will be the last time"

Not one of these attempts brought forth any honest or extended discussion of the literal reality which was being being referred to.

In such a setting token remarks and gestures of an aggressive or joking kind seem to represent the only viable means remaining to residents of raising this most personal and significant issue. Hence the examples of black humour quoted.

The assertion of the imminence of their own death is one, particularly salient example of the impromptu strategies through which residents seek to negotiate their passage through Highfield House. The following section explores a series of events within the home, showing them to be residents' more considered attempts to validate their responses to Highfield House - and to assume a degree of symbolic mastery.

2.1 Just a Song at Twilight.

Though fieldwork reveals the impromptu strategies, the practical mastery, through which residents manage the implications for their daily lives of admission to residential care, an examination of the construction and rehearsal by the residents of a song can give further insights (Hockey 1983). Careful analysis of material such as the song can show how residents interpret their present social and physical conditions and validate their responses to these conditions. The song's career had begun in the spring when an Easter card bearing 'inspirational' verses had been sent to Henry Johnson a member of a small group of relatively fit, less dependent residents whose friendship with one another in many cases stemmed from childhood residence in the former village, now a city suburb, adjoining the home.

> **"We liked the words so much"**, Henry told me
> **"that we asked Arthur to set them to music"**

Arthur Grant was a lifelong friend, former schoolteacher and chapel organist, now resident in the home. The 'we' is a reference to Henry's associates within the home. The intention was to prepare the song for performance at the Christmas concert held every year in the home. Previous concerts had attracted the attention of local television, thereby making it very much a public performance.

The verses can be seen as a fragment selected by a particular group of residents from their external environment and appropriated for a specific purpose within the home. It becomes meaningful to the extent that it absorbs and embraces that which is critical within the bounded social context of its peformance. It is filled with meaning through its deliberate adoption into the lives of its singers.

It is the difference between these two kinds of fieldmaterial, the 'native account' and the observed incident or utterance, which Bourdieu's terms, symbolic mastery and practical mastery, usefully point up. Bourdieu suggests that the two kinds of material are interrelated. In the context of ageing in residential care, that interrelationship is critical. A strategy such as the generating of the song is one of the few avenues remaining to residents through which their more idiosyncratic forms of practical mastery may be made coherent.

Thus the creation and preparation of the song for performance within a public setting represents a series of conscious, independent choices and decisions on the part of certain residents. As a social group they are residents who stand in marked contrast to those whose response to extreme old age and institutional life has been a self-elected or an enforced social isolation. The members of this group have a capacity for a greater sociability which distinguishes them but does not restrict their influence. As representatives of a common memory of significant events, experiences, roles and status within the former village and the city of which it is now a suburb, Henry, Arthur and others of this group offer a reference point of some kind to those whose present withdrawal into deterioration belies their former awareness and involvement with the affairs of the locality.

Staff too are not unfamiliar with the biographies of those associated with this group. Their relationship with these individuals arises less from the close physical contact used in care of very dependent residents and more from the complex verbal interaction needed to ensure co-operation from those more accustomed to independence and respect. The predominance of men within this group contributes significantly to the nature of this relationship. Evers draws attention to responses to dependency upon female nurses which are quite specific to male geriatric

patients (1981:108-130). Unlike their female counterparts who have been required to resign their former personal responsibility for caring to which they are accustomed, male patients are not threatened with the loss of so significant an aspect of their former role once admitted to hospital. Though men may aquit themselves honourably of their working role at retirement, women continue to define themselves through the quality of care which they provide within their own homes. Thus the relationship between male patient and female nurse corresponds to prevailing notions of the appropriateness of male dependency upon female caring within the domestic environment. The points are borne out in the quality of relationships to be found within a residential home. As Evers notes, only upper class women learn to find it appropriate to receive domestic care from other women (1981:110), and it is interesting to note that either an independent role in business or a sheltered world of wealth and high social status characterises several of the female members of the social group associated with the construction of the song.

Having identified the source of the song and discussed the common attributes of those who constitute its source, I will now explore the social and cultural meaning of the statement put forward by them. I contend that the offering of these verses represents an attempt to display symbolic mastery on the part of certain individuals. It is one which serves both to articulate and to reinforce the more disparate attempts made by the socially isolated to interpret their relationship to their present situation.

2.2 Reading out the Meaning.

During the late autumn of that year many of the residents of the home met together in the dining-room once or twice a week to rehearse the singing of the verses, 'Hope', now set to music composed by Arthur Grant:

HOPE

There's always a hope - though it may be quite small 1
There's always a star - tho' the darkness may fall - 2
There's always a gleaming of gold in the grey, 3
There's always a flower growing wild by the way. 4

There's always a song floating out on the air, 5
There's always a dawn to the night of despair - 6
There's always a path for the faithful to tread, 7
There's always a bend in the roadway ahead. 8

There's always a hope - but we've got to believe, 9
We've got to be ready to see and receive 10
The hints and the signs 11
Although faint they appear 12
To wait and to trust till the meaning grows clear. 13

And when through the murk of the shadows we grope 14
We've got to remember 15
We've got to remember 16
There's always a hope ! 17

(Arthur Grant's underlining)

From their imprecise, inspirational sentiments the verses are readily identifiable as an example of a particular genre of quasi-religious texts and poems, often to be found on calendars and greetings cards and perhaps best exemplified in the work of 'Patience Strong'. Like magazine horoscopes, it is the vagueness of this form of writing which is particularly important in that it allows the reader to impute their own specific meaning to its imagery.

The verses were originally printed on an Easter card. Their theme is 'Hope', that which was given to the world through the resurrection of Jesus Christ, and is central to the Christian concept of Easter. Written in the characteristically imprecise style of their genre, the verses were found to be appropriate to a quite different point in the Christian calendar when detached from an original context of chicks, rabbits and budding flowers. Sung by very elderly people in the dark November afternoons leading up to Christmas, the words which had previously lent

vague Christian undertones to Easter's association with spring, fine weather and fresh hopes now took on a more profound and urgent 'religious' reference.

Sense and reference are thus, again, being manipulated - in this case by a relatively powerful group of residents rather than by a single, powerful member of staff, the Matron. Once detached from its original set of referential meanings the card's internal sense meaning had an entirely different reference predicated upon it.

It is that more profound and urgent set of meanings which is revealed if the images used in the verses are seen in relation to the comments and conversations which pattern the daily round within the home. Familiarity with the texture and the quality of residents' daily lives is enlightening in suggesting why these particular verses spoke to them with such clarity. Such was the energy generated in the appropriation, transformation and rehearsal of these verses that it may be inferred that the residents concerned recognised certain very crucial themes traced in the simple images of these lines. I will now discuss the resonance of these simple images - of old age, of the natural world and of an afterlife - and so describe the three themes which are of particular significance for those who age in residential care.

2.2 (a) Images of Old Age.

'There's always a dawn to the night of despair'
(line 6)

This line is perhaps the most immediate point of identification with the verses for residents encountering the bodily conditions of old age. It readily articulates the experiences of those condemned by too many daylight hours of dozing to suffer the persistent aches and pains of an ageing body through long wakeful

nights.

'And when through the murk of the shadows we grope'
(line 14)

is similarly resonant for those whose failing limbs and eyesight are tried by the unceasing requirement to edge their way back and forth along the corridors which lie between bedrooms and dining hall. Such experiences are also alluded to in the phrases:

'though the darkness may fall'
(line 2)

and

'the <u>bend</u> in the <u>roadway ahead</u>'
(line 8)

a bend which may appear at times unattainable when a zimmer frame compensates so poorly for the limbs' lost vigour. The word 'grey' in line 3 has multiple reference points in a bland physical environment where extreme old age and lack of fresh air are everywhere reflected in greying hair and flesh, and all movement is made across monochrome lino and carpet tiles. Any gleaming of gold to be found in these grey surroundings arises from such chance events as a joke, a visitor or a burst of spring weather.

Through the imagery of bodily discomfort the concept of a journey is implicitly traced - for example:

'there's always a <u>path</u> for the faithful to tread'
(line 7)

and

'when through the murk of the shadows we grope'
(line 7)

Suggested through the imagery of physical suffering, the motif of a journey is implicitly lent additional associations with the Christian ideology of life as pilgrimage. As they grope through the murk of the shadows, it is the faithful, the believers, who find a path and a bend in the roadway ahead. It is a journey of suffering, a night of despair, which not only has an ending or a dawn, but also leads towards meaning.

Remembering that in one form or another many residents have experienced a dramatic change in their domestic and social circumstances brought about by deterioration in their physical state, the significance of a journey motif within the chosen song becomes apparent. In many cases changes in personal circumstances have occured at a time in life when the uncertainties and upheavals of youth have long since given way to the stability and predictability of a long-established marriage within a familiar and well-ordered domestic environment. Bereft of reference points previously taken for granted the resident confronts a solitary one-way journey into an indeterminate future. This period of up to thiry years following retirement is singular in its lack of classificatory markers comparable with the various rites of transition whereby the individual has negotiated their passage through the earlier years of life. As Hazan asserts in 'The Limbo People', a study of a Jewish day-centre for elderly people:

> ...the elderly are confronted with two conflicting dimensions of time. Their position in society consists of static elements whereas the unavoidable process of disintegration changes conditions and abilities. (1980:47)

The conflict between two very different dimensions of time is particularly marked for people who age in residential care. While the rigidly repetitive routine of the institution creates a sense of timelessness, the individual's subjective experience is of a personal time dimension characterised by progressive physical decline.

Remarks from residents such as:

> **"You never know what to expect when you're getting old. You never know what's coming next"**

> **"You never think about old age, do you, you never think. You ought to prepare for it"**

and most commonly of all:

> **"I never thought I'd come to this"**

attest to the fact that the unprecedented bodily experiences of ageing in the unfamiliar environment of residential care may bring with them an acute sense of diorientation or discontinuity between past and present. As changes in the body multiply, the experience of an unanticipated rupture in one's path through life breeds a growing sense of uncertainty and insecurity with respect to the future.

For example, Mrs Dent, an eighty-four year old resident, would talk at length about the deterioration in her condition which she had observed during her first eight months in the home:

> **"I know I'm getting old but I never expected this kind of deterioration"**

she told me, going on to refer to residents who had been in the home for up to eleven years. She confided her fears of the unpredictable range of suffering she faces during the indeterminate period of time remaining to her.

Uncertainty about the unknown course of future deterioration is compounded by the awareness that any one of the physical impairments which arise may lead rapidly to death. Maggie Carstairs, already referred to, had had a mastectomy during late middle age and the illnesses of her eighties sustained her fear of the recurrence of cancer. As each aspect of ageing manifested itself she would ask staff:

"Do you think this is the end ?"

seeking out the Catholic priest to make her funeral requirements quite explicit.

Gran McCardle, also a Catholic and in her mid-nineties, was wont to remind staff that:

"You can be struck down in a moment"

Another resident, Mrs Porter, received an unprecedented number of cards and presents during the week leading up to her ninety-first birthday. She confided her appreciation of these gifts to a staff member and added a query as to why people had been so kind to her this year. Was it to be the last ?

Thus to those whose passage through physical deterioration is contained and constrained within the static and repetitive routine of the institution, the motif of a journey which is traced in the imagery of physical suffering has a very personal significance. The song acknowledges the fact that though staff may manage a repetitive cycle of admissions and exits to and from

the institution, the resident encounters a solitary one-way journey into unknown and uncertain personal territory. The acknowledgement is couched in a form which not only offers comfort by asserting an end to suffering, but also lends purpose, meaning and therefore dignity to that suffering by implicit reference to the Christian concept of life as pilgrimage. Though a present of discomfort and constraint continues to replicate itself day after day, as the resident moves back and forth between the same bed, armchair and meal table, their sense of uncertainty about the nature of their fate as individuals is both acknowledged and transcended through the image of a painful journey which leads towards a meaningful destination. As an interpretation of the process of ageing which is counter to the framing provided by the institution, the song can thus be seen as an attempt to display symbolic mastery on the part of residents.

2.2 (b) Images of the Natural World. In common with many poems and texts of this kind, images of the natural world are used extensively in these verses - for example:

> the star, the wild flower, the dawn, the gleaming of gold in the grey, the song floating out on the air, and the bend in the roadway ahead.

In the In Memoriam columns of provincial newspapers similar examples are to be found.[3] These images are used to fulfil two different purposes in the verses, 'Hope'.

First the external world of nature is used to give metaphoric form to the hopes and fears associated with human hardship and struggle. For example:

> 'There's always a star - though the darkness may fall'
>
> (line 2)

and

'There's always a <u>flower</u> growing wild by the way'
(line 4)

In this way the uncertainties of human life are placed within the broader context of the cycle of nature and the message to the reader is that present hardships or discomforts can be accepted as part of a larger pattern. Comforts and relief will come in their own good time, just as spring follows winter and sunshine follows rain. In other words, it is not for the individual to strive for, or seek to possess, happiness. It will come like the flower growing wild by the way and the song floating out on the air.

Second the images are used to endorse and validate the Christian message by drawing on that separate body of folk wisdom, the Lore of Nature. For example, line 1 expresses the rash and contestable assertion that, however small, there is always a hope. The form of this line is echoed in the following seven, all of them variations on the adage, 'Every Cloud has a Silver Lining', all of them referring to that which, by the Lore of Nature, is firmly held to be 'true'. By the eighth line the validity of the first line is well established and the reader/singer is open to the injunctions of the third verse.

Thus images of the natural world are used:

(1) to suggest that both suffering and its relief are inevitable, each to be accepted in its turn, that 'into every life a little rain must fall'.

(2) to invoke a body of folk wisdom which lends further weight to the message of Christianity.

These roles are essentially overlapping or mutually reinforcing. The presentation of suffering as something to be accepted as part of nature's cycle underscores the song's Christian injunctions that the individual should be humble, patient and trusting.

What can be inferred from residents' choice of verses bearing messages of this kind for their public performance ? Private comments suggests that the uses to which images of the natural world are being put in these verses correspond to many of the strategies through which residents seek to come to terms with their present situation.

It must be remembered that residential care is made available only to those:

> 'in need of care and attention not otherwise available'[4]

No matter what form of response residents offer, their continued and inevitable presence within the home ultimately represents passive acceptance of care. The active seeking of alternatives is no longer an option for them. And indeed, when new residents are asked how they are settling in, they offer replies such as:

> **"I'm beginning to but it will take time. It takes a while to get used to it but I'll just have to"**
>
> **"I'll never be happy here but I'll have to stick it, 'cos I won't live that long, much longer"**
>
> **"I accept things the way they are here. I have to, there's nothing else for it"**
>
> **"I'm not happy here but I'll just have to make myself happy"**

"You never know what's coming next. You just have to accept it"

To express acceptance in words such as these is to betray the helplessness and desperation from it stems. It is the one strategy open to all who encounter hardship and loss of power yet it inevitably implies personal failure and loss of integrity.

Hence the significance of the use to which natural images are put in the verses. As noted, they describe a present condition of darkness, despair and greyness. All that remains to the faithful is hope. Only by 'waiting' and 'trusting' can they hope to stumble upon the 'wild flower', the 'song' and the 'bend in the roadway ahead'. Couched in religious terms which are validated by references to the natural world, the acceptance of hardship assumes a dignity and stature which distinguishes it clearly from resignation, apathy or passivity. In their singing, residents are implicitly invoking the authority of two traditional sources of truth, Christianity and the Lore of Nature. Thus they validate their one remaining option, acceptance, and allay any notion that it may be little more than a giving up.

As the comments of new residents testify, they keenly feel the loss of alternatives and accept residential care because they have no choice. They can be compared with more settled residents, such as Henry Johnson, Arthur Grant and others associated with the song's creation, who have retained their health and been able to create a role for themselves within the home. Arthur Grant summed up his life story and personal philosophy with the following words:

"You never know how things change in the world. Where you get to. How things link up or break up. That's life, you take it as it comes. Sometimes its good, sometimes bad"

Among residents such as Arthur, acceptance has been elaborated, through reference to cultural values rooted in their past lives, into a system through which dignity and status may be acquired. Proverbs, aphorisms, systems of authority rooted in former professional lives and religious texts are all cited in support of residents' acceptance of present circumstances.

Thus Mr Bradbrook, complaining that care staff had hurt his back by dropping him hard onto a chair after his bath, curtailed his resentment with the opening line of a hymn:

> **"Well...we but little children, frail and helpless all ..."**

He expresses acceptance of his present helplessness and interprets it in terms of the Christian metaphor of human beings as children and God as father.

Ethel Halliwell also ended a series of complaints with the biblical text:

> **"We must learn not to kick against the pricks"**

Mrs Porter invokes professional rather than religious values. Formerly associated with one of the city's most thriving businesses, she said it was important to accept rules and regulations. There was someone at the top and what she said had to go. Mrs Porter had been at the top herself and she knew that this was how it had to be.

Like a religious ideology or system of order stemming from a previous professional life, other sources of folk wisdom are made use of in the same way. Ada Peters attributed her isolation in old age to her mother's reluctance to allow her to marry. She repeated the adage:

"Mothers shape their daughters' destinies"

Mrs Dent, struggling to make herself happy, drew courage from the aphorism:

"Nothing ventured, nothing gained"

The value which is attributed to some form of stoic acceptance is also revealed in the transformation, through language, of unhappiness or the unneccesary display of helplessness into a form of illness and therefore pathological. Thus Mr Bradbrook described his homesickness as **"get-out-itis"** and Albert Headley's willingness to allow staff to shave him was described as **"lazyitis"**.

In these and many other examples, as in the chosen verses, traditional sources of authority are invoked to validate a patient, trustful and accepting response to hardship. By drawing on such traditional values as discipline, hierarchy, and Christian humility and trust, residents are able to impute meaning and therefore grace and dignity to an otherwise demeaning acceptance of failing health and lost independence.

1.2 (c) Images of an Afterlife. Though I have dwelt so far on the relevance of the song's images for the present circumstances of residents' lives, the original significance of its metaphors must not be overlooked. Thus the 'dawn to the night of despair', the 'flower' and the 'song' are all faint hints or foretastes of that much happier life which lies beyond death.

I suggested that the appropriation of the verses by the residents lent them a more profound and urgent religious significance than was originally intended on the greetings card. Sung by those for whom death is an everpresent possibility, the Easter message of the gift of hope for the resurrection to eternal life has a very

immediate personal relevance. The resurrection ceases to be an intangible precept of the Christian religion and instead assumes the pressing reality of an imminent event. Closing a 'choir practice' Arthur Grant, in his role of choir master, sought to encourage the more faint-hearted by promising a growing repertoire by that time next year. Awareness of what the future held led him to add the proviso:

> **"...if we're all still alive by then"**

Thus underlying the significance of the verses for a here-and-now which is centred around the constraints of ageing in residential care is a more fundamental layer of meaning associated with the immediacy of dying.

Set to music, the image of a pretty landscape with wild flower, song and star constitutes a vehicle whereby residents may implicitly affirm that their bodies are failing, that they stand very close to personal annihilation or transformation to an unknown state. The preparation of this statement for expression in a public setting is an acknowldegement of all the private statements which are being made in bedrooms and bathrooms throughout the home. Talking with Mrs Heslop, resting in her room after a period of ill-health, the subject of her daughter's family, living in the north of Scotland arose. Stressing their remoteness she told me that in the past she had had to fly up there:

> **"I'll fly there again"**, she added, **"either here or here"**

Her hand, raised from one level to the next revealed the meaning of her words. Little distinction remained between plane flights and heavenly flights. My suggestion that a few day's rest would help restore her strength brought the reply:

"If not in this life, then in the next. I'll be ninety-three next month, you know"

Comments such as those made by Arthur Grant and Mrs Heslop suggest that the Christian concept of the resurrection to eternal life, alluded to throughout the verses, constitutes a public acknowledgement of residents' private preoccupations with the nature of their own death. It is upon this pre-occupation that the overall sense of the verses bears most directly. The slender hopes and the faint hints and signs, apparent only to the trusting as they grope for a path through the murk of the shadows, all refer to that most critical but elusive of goals, the discovery of meaning. Pre-occupation with the approach of death inevitably presages reflection upon the long life that has gone before.

Those who care for the residents are aware of, and skillfully avoid, the rambling repetitiveness which periodically comes to the fore in conversation with elderly people. The young are locked within the linear flow of a time dimension directed towards the next days off and the forthcoming summer holiday. They lack the telescopic vision of elderly people for whom meaning lies not in the foreseeable achievements of the future but rather in the collapsing, condensing and integration of the decades which separate past from present experience.

2.2 (d) <u>The Search for Meaning</u>. This aspect of ageing, the search for meaning through repetition and reminiscence, has been discussed by many writers on the subject of ageing. Myerhoff writing of the elderly members of a Los Angeles Jewish Day Centre says:

> Their histories were not devoted to marking their successes or unusual merits. Rather they were efforts at ordering, sorting, explaining, rendering coherent their long life, finding integrating ideas and

> characteristics that helped them know
> themselves as the same person over time,
> despite great ruptures and shifts.
> (1978:33-34)

The search for coherence, the creation of life history which transcends the changes and losses of the recent past, represents a major if unacknowleged pre-occupation of the residents of Highfield House. Faced with the certainty that one's past life is one's whole life, that admission to care has brought with it social death in one form or another, the achievements and the regrets of the past assume their ultimate dimensions. Nothing further promises to dwarf, diminish or erase them and it is to these events and experiences that the memory returns during the vacant hours which remain. As the verses repetitively assert:

> 'We've got to remember
> We've got to remember'
> (lines 15,16)

Among female residents the need to repair gaps and to come to terms with losses is a major pre-occupation, often focussed on the meaning of relationships now curtailed by death. By contrast many male residents seek to sustain or find new forms for the roles through which integrity has previously been established. As mentioned earlier, the roles formerly assumed by female residents are largely usurped by the all-embracing provision of domestic care within the home. However neither avenue is by any means the exclusive province of one or other gender.

As already noted a sense of uncertainty can arise through admission to care and the loss of the assumed reference points through which the self was formerly defined. For many residents this sense of dislocation remains and conversation returns endlessly to the events which conspired to produce the present situation.

For example, Alice Heslop seldom allowed a day to pass without mention of the doctor who **"tried out"** a powerful drug on her, causing a black-out in the street. At ninety-two Alice lived alone and, though she continued to play bowls for her city up to this point, the injuries resulting from her collapse led rapidly to permanent admission to Highfield House. Alice offered a very coherent account of her entire life history - the twenty years of care she gave her parents, her marriage at forty, her widowhood at sixty to be followed by ten years of housekeeping for a friend, **"the happiest ten years of my life"**, and, latterly, the twenty years of independence devoted to bowls matches and charity work. She described her cousin's daughter as:

> **"the closest relation I've got. I've nobody else. No father nor mother, no uncles, no aunts, no husband, no children"**

Alice does not perceive a link between her present situation and an early life devoted to the death-bed requests of first her father and then her mother. She sees no irony in her present lack of supporting family which stems from the very extended support she gave to her own parents.

> **"I lost most of my young life"** she told me,
> **"but I have the satisfaction of knowing that I did the right thing by my parents. I kept my promises to my father"**

She finds meaning in her past life, a sense of personal integrity arising from her devotion to the ideal of filial care and support. Her present plight she attributes entirely to her doctor's negligence, an abrupt and unneccessary curtailment of her independence which makes no sense to her. It is to this that she returns incessantly in her conversation.

Alice's unanticipated loss of her home and her independence arose from the chance event of a medical oversight. For other residents the death of one or more family members produced the same result. A banal opening remark or the handling of a piece of jewellery frequently precipitates a description of the unexpected heart-attack or stroke which had robbed many female residents of their husbands. The incontinent, immobile and inarticulate elderly lady who stuck her tongue out at the Matron, would urge staff to quickly draw back her bedroom curtains each morning. Behind the curtains stood a photo of her, taken in her twenties, standing beside the husband who, in his obsessive love for her, had refused her children who might absorb her affections. Like Alice, this lady had devoted herself to a bond which precluded the growth of a supporting family. During ten years of life in Highfield House the significance of this attachment was both sustained and sustaining through the veiled photograph to which she awoke each morning.

Though some childless women found enduring meaning in the causes which had drawn them aside from motherhood, those whose children had already died became increasingly pre-occupied with losses which had occured up to half a century previously. Annie Crosby[5] told me:

> **"I had a stillborn boy, you see, and I had a terrible do...a complete hysterectomy. And ofcourse when I was younger I didn't feel it so much but now I've no-one to care for me"**

My own two children were invariably the focus of her conversation with me.

Mabel Carey's mention of her husband's recent death, precipitated by my comment on her snake ring (worn by him through two world wars) was rapidly followed by a description of her son's much earlier but most horrific death by drowning in a cess pit in

India.

Mabel's friend, Hannah Archer, had had eight children by her now dead husband. Her story of a lively family life led her back repeatedly to Vera, her quiet and clinging daughter who died in her forties from heart trouble. Hannah had overridden Vera's pleas not to be admitted to hospital and it was there that she died within a few hours.

Thus in many examples it is the dead rather than surviving child or sibling who absorbs the attention, whose photo is framed on the locker. As they age and die, elderly parents come to a painful realisation that their only assured immortality is lost to them in the death of their child. For female residents in their late eighties or early nineties, many of them mothers of large families, the deaths of one or more of their children, themselves in their sixties and seventies are timely and predictable events in the eyes of their contemporaries. Yet when the life of the child is subsumed within the life of the parent, a disordering circularity arises within the linked, linear chain of successive generations. Responsibility for the child's immortality rests paradoxically with the parent and the search for meaning becomes onerous and pressing if no-one is left to succeed them.

This sense of responsibility is pervasive and one final, contrasting example illustrates a now aged child's desire to account for and place a parent who was lost to them many years previously. The postcard pinned beneath a religious text above Elsie Crawford's bed showed a Lancashire churchyard with graves prominently framed in the foreground. After many years of family life in the North East, Elsie had travelled back to Lancashire in her old age to find her mother's grave. Her purpose satisfied, Elsie told me she felt **"easier"**. Moreover, in the same churchyard she said she'd **"found"** some of her old schoolfriends by picking out their names on headstones. Her journey had served

to give form and order to a long distant past and her black and white postcard recorded its permanence.

In addition to the attempts of female residents to understand and impute meaning to past experience, male residents make use of vestiges of former roles and status to lend meaning to the present. Scrapbooks and medals become an evermore vital aide-memoire in the telling and re-telling of professional, social and domestic autobiographies. Sam Hastings, a friend of Arthur and Henry, had once enjoyed prominence in both local politics and the Methodist Church. While jewellery and photographs give access to the fluid, emotional aspects of women's past relationships, Sam's room contained a collection of his very detailed accounts of the life and times of the people the former local village. Written ostensibly for his family alone, Sam had placed copies within both the public and university libraries of the city. His status within the home rested heavily upon the scope and accuracy of his writing which bore witness to his former positions of power and influence. Staff borrowed and read his books, the trainee who lost one being subjected to extended criticism. Sam was not alone among residents in possessing such a collection. Mr Bradbrook too had scrapbooks of a similar if less polished nature.

In addition to such possessions, Sam, Mr Bradbrook, Henry and Arthur had all succeeded in assuming roles within the home which served to sustain their former status. Sam grew plants for sale at Open Days (together with Mrs Heslop), thereby raising money for another television set for the home. Henry attended funerals, committee meetings and announced forthcoming events. Arthur resurrected his former roles of schoolteacher and Chapel fiddle player to compose, play and rehearse the musical form of the verses.

In these and many other examples residents draw on the significant events and experiences of the past in order to extend their meaning into the present and into the rapidly shrinking future.

Mr Bradbrook offers one final example in his enduring loyalty to a childhood memory of Terry's sweet factory in York. His rambling conversation is punctuated with the story of his Sunday morning visits to the factory when a knock on the door unfailingly gained him a bag of Terry's sweets from his caretaker grandfather. He continues to re-create this Sunday morning experience in his regular Thursday afternoon's purchase of Terry's sweets from the home's trolley 'shop'. Like the sweets which have given him so much pleasure, Mr Bradbrook unfailingly describes himself as:

"Manufactured in York and came to life in Sacriston"

2.3 Performing the Text.

Returning to the choir practices, the 'public' context within which the text, as song, was first manifested, its social function as outsider-oriented discourse can be considered.

Its creation and instigation as material suitable for the Christmas concert was the work of a very specific group of residents. Its expressiveness as symbolic mastery rests upon the unique position of its originators. Whilst sharing a common experience of physical decline and loss of social roles, this group of residents retained the capacity to perceive and to articulate the paradoxes inherent within that common experience. Through their former status within the locality, their relative independence of staff's physical care, and their ability to assume prominent roles within the home, these residents represented a desirable model of ageing. As an alternative interpretation of a present otherwise characterised by personal failure and a loss of hope, meaning and self-esteem, the power of

the song rests upon its instigation by the one social group within the home who could offer a model of this kind. That its form corresponded to a familiar genre of inspirational writing, and its content contained allusions to the long-established values ascribed to Christianity and the world of nature, furthered the authenticity of the song to the ears of its potential singers.

As noted this last period of life is singular in its classificatory markers as compared with the various rites of transition through which individuals negotiated their passage during earlier years. The space between entry to and exit from the home is, in may ways, uncharted personal territory. It is within this territory that residents have set their song. It is a symbolic statement which implicitly condenses the lost independence of the past, the pressing needs of the present and the imminent event of the future. In making this statement the singers orient themselves within the otherwise very disorienting concerns and pre-occupations of their past, present and future circumstances. Form, order and meaning are given to the otherwise unstructured descent into physical decline and death. Thus in the last verse, those who presently grope through the murk of the shadows are exhorted to remember and to hope, to look back and also to look forward.

In this way the song articulates the experiences and the needs of the insider, the member of a negatively perceived social category. Under the guidance of their more able and less circumscribed fellows, this interpretation is offered by residents to an outside audience.

Staff's responses to the offering of the song affirm its power as an alternative interpretation of ageing. Though they were asked to go to choir practices for 'support', they begrudged residents their presence in this form and offered little support. Behind the long rows of chairs, laid out school-room fashion for the

residents, the staff sat clustered above them on table-tops. Making faces at one another, hoping for some fun, the staff did not sing. Though official and unofficial rest breaks in the staff room are longed for and sought after throughout all working hours, the opportunity to sit down with residents for an hour or more was not welcomed by staff. One of them described Arthur's musical setting as **"tuneless"** and drew attention to the residents difficulty in singing it.

Staff's response indicates that the occasions of the choir practices were very much of the resident' own making. Required to associate themselves on an equal footing with residents, to express subservience to Arthur in his role as the haranguing school-teacher, staff were at pains to create what distance they could between residents and themselves. Sitting above and behind the ranked rows of elderly people, staff displayed their capacity for both physical agility and lively sociality by clustering together in informal, casually perched social groups.

Though rehearsals continued, Christmas came and went without a performance of the song. As Arthur put it in January:

> **"We weren't asked. We're giving it all up. We're vexed"**

In the busy institutional schedule of the home, the wavering efforts of the residents to acknowledge and give form and meaning to their own physical deterioration and closeness to death, were quietly overlooked. Their difficulties in singing betrayed the aptness of its images for this context. It lent to residents the power of the weak and as such was quietly diffused and distanced by staff.

Arthur ended his short statement by saying:

"Well, we might try again next year"

True to the sentiments of the verses, Arthur had waited trustingly to be asked to perform his work. Being overlooked, he expressed his anger succinctly but, recognising his own impotence and the impossibility of satisfactory explanations he substituted acceptance for anger and expressed his hopes for the following year. By June he was dead.

3 SUMMARY

Field material has been drawn upon extensively in this chapter. Through the piling of one example upon another the meanings which are subject to manipulation within the context of residential care can be read out more clearly and in greater depth.

Earlier chapters[6] drew out in detail both the clarification and the fusion of the literal and the figurative, of 'care' and 'control', which the Matron embodies. Field material presented here exemplifies her staff's powerful cultural commitment to the maintenance of that figurative homeliness where 'life' and 'death' remain firmly and clearly separated. In pursuing this task however the literal reality of a slowly encroaching deterioration is continuously discovered - and must continue to be systematically controlled.

'Marking time', the later part of this chapter, describes residents' perceptions, and experience, of that same gradual process of ageing. The breaching of the continuum of past, present and future which is necessary for the maintenance of institutional time and space can be seen as the implicit focus of residents' attempts at both practical and symbolic mastery. As shown, residents' references to the loss of both a past and a future are a painful underscoring of their present helplessness.

The appropriation and re-contextualising of Easter verses is an attempt to generate a powerful symbolic statement, one which might:

> ...correct the symbolic effects of strategies imposed by other necessities. (Bourdieu, 1977:43)

In addition, the performing of the text involves the resurrecting and re-enacting of the more powerful, controlling social roles through which a small group of the residents once defined themselves.

Residents' sad failure to bring their transformative strategies to fruition in a public performance can be taken as a measure of the threatening power embodied in their symbolic statement.

NOTES

1. See Chapter Six, pages 164-168.

2. See Chapter Seven, page 184.

3. For example:

> The brightest star in the sky tonight
> Is our darling Mother saying goodnight.
> (Durham Advertiser, 2.12.78)
>
> A ray of sunshine came and went
> A precious gift was only lent.
> (Durham Advertiser, 2.2.79)

If heaven is full of roses, pick a bunch for us
Take them to our mother, Lord, and tell her they're from us.
(Durham Advertiser, 5.10.78)

You potter no more in your garden
Down the path you no longer walk
Because you are sleeping peacefully
In the most beautiful garden of all.
(Durham Advertiser, 2.2.79)

4. The National Assistance Act, 1948, Pt.III, Section 21, requires that residential care shall be provided 'for those in need of care and attention not otherwise available'.

5. See Chapter Nine, pages 251-255.

6. See Chapter Six, pages 162-168 Chapter Seven, pages 187-195. and Chapter Nine, pages 255-260.

CHAPTER ELEVEN

COMING TO GRIEF: CHANGING EXPERIENCE THROUGH THE DEATH-AWARENESS MOVEMENT

An examination of the minutiae of the daily lives of residents and staff of Highfield House[1] revealed the management of decline and loss as a central but covert pre-occupation within an institution ostensibly offering a homely, independent way of life for very elderly people. Within the constraints of, and indeed as an aspect of, an asymetrical relationship of power between staff and residents, death and dying are repeatedly brought to mind.

This chapter explores the related process of coming to grief - through both bereavement counselling and through Hospice care. Like the residents of Highfield House who retrospectively transform the rupture of their past lives and the forms of social death suffered at admission, bereaved people are engaged in the retrospective repair of a traumatically fractured lifecourse. Again my focus is the insider's experience, as it arises out of systems of support and care such as the Cruse Organisation for Bereaved People and Strathcarron Hospice.

My starting point is material drawn from counselling visits to the homes of bereaved people. As insiders' accounts of personal experience this material must be understood within the social context of its utterance - that is as conversation between a bereaved person and a counsellor. Thus these are accounts of grieving which, in being offered to a counsellor, are themselves constitutive of the process of coming to grief. Repeated, often at each counselling visit, the telling, re-enacting even,[2] of such accounts is one of the means by which a bereaved person may act upon the past event of a death, so transforming it into a text. Framed within the present context of talk with a bereavement counsellor about the emerging empty space, the text

becomes amenable to new readings, meanings which lend coherence to the otherwise unpredictable flow of life into death. 'Life' and 'death' can thus be made to stand in manageable distinction from one another, their relationship in time and space becoming orderly and therefore more sufferable.

Additionally the 'conversation' itself must be understood within its wider cultural and social context. While organisations such as Cruse have arisen in response to the idea that widespread 'social supports' for the management of death have dwindled, counselling is not offered routinely to all bereaved people but rather to those individuals whose personal circumstances or temperament are seen to be problematic. Their accounts of grief thus reflect the idea that for them bereavement has involved the intrusion of obstacles or problems - rather than being a 'natural', painful exposure to loss. Such individuals can be seen to have particular difficulties in passing through the disorienting fusion of a lost, past way of life and an unbearable, unthinkable present existence. Those aspects of the present Western context of bereavement which were discussed previously[3] are nonetheless common to the cases cited here - and also to the more extensive range of bereavements which are managed without the support of a counsellor. Sharing the same broad cultural milieu the differences between bereavements are ones of degree rather than kind.

1 BETWIXT AND BETWEEN; CIRCUMSTANCES LEADING TO THE MANAGEMENT OF GRIEF THROUGH COUNSELLING

Exclusive (marital) relationships may bring difficulties after the death of one or other member. Help is often sought by individuals in their sixties and seventies who have been partners in very 'private' marriages. At the death of the spouse the previous sense of the self as a separate entity, enduring over time, is brought up sharply against the sense of a fractured,

massively incomplete self for whom wholeness lies entirely in the past. Certain phrases recur:

> Mrs Crawford talked about her marriage. She and Ian had always been **"very close"**, they'd done everything together. Now she wonders if they shouldn't have lived more separate lives. She only has one daughter - no other family. She was married for thirty-four years and felt that her life really began when she met Ian.

and

> Mrs Crawford felt she'd been spoilt - she and Ian had completely filled each other's needs and she'd never had to look around outside for companionship or entertainment. Again she pondered over whether they had been right to devote themselves so entirely to each other.

> Mrs Jackson said she and Gordon had built their world around each other and the home - now the centre of her world had dropped away and felt no interest in the home at all. Shopping was useless - she didn't know what to buy and always came back from town with too much - ended up just pushing it in the fridge.

Living within the confines of relationships of this kind, links with the outside world are not sought or maintained. For example Mr Dawlish, a widower in his early seventies, lives alone and is socially isolated, having spent the last six years caring for his wife:

> Mr Dawlish stressed again that he and Majorie never had anyone to the house - except family (though he has a brother living nearby to whom he never speaks). He recalled going out to find friends in his youth, enjoying it. But it hadn't been necessary once he had his own family. He explained that as he and Majorie came from police families it had not been customary to have visitors - the police were expected to keep themselves apart. People were nosy and might see things, reports, which were confidential.

> Mrs Crawford gave some clues about their relationship, saying that Ian never went out without her. She spent her days at home, quite content to dressmake and do housework while he was at work. The only time she can remember him going out alone was to a friend's retirement drink. Ian had been very concerned that she'd be alright without him and returned almost exactly at the time promised.

Within such relationships illness or disability can provide a powerful focus for an exclusive intimacy:

> Even before Mrs Crawford's illness (rheumatoid arthritis) Ian had always washed her hair for her and throughout her illness he'd always put out her pills for her. After his death she had no idea what she should be taking. She said she was very dependent on him - he always saw to everything.
>
> Mr Dawlish talked over all Majorie's illnesses again, repeating the words they said to each other, imitating the voices they used. The detail of these reminiscences - really too intricate to record - reveals a prolonged period of intense intimacy between them. Her **"coo-ees"** when she wanted something had become deeply familiar to him. He talked of his awareness of her every movement through the night - how watchful he was in case she should try to get out of bed.

An associated difficulty which can lead the individual to Cruse is the lack of a supportive social network, particularly within the extended family. Physical distance is a problem and older bereaved people often have no children living close by. Particular pain is felt if grief imposes additional pressure upon relationships which, even in the past, were unsatisfactory. Mrs Jackson, very agitated in her grief, described many rebuffs:

> Over the phone Mrs Jackson told me that there had been more upset with her son and daughter-in-law and when I arrived she was shaking and weepy. She said her son had been to the house a fortnight ago and told her she

> couldn't come to their house until she was better - it was upsetting his wife, her nerves were bad and she was worried the grief would spread.
>
> Mrs Jackson had turned her hopes towards her own family again and they'd made no move towards her. Her sister in a nearby town said she was having no visitors until after Christmas. Mrs Jackson said **"But I'm not visitors. I'm family"**. However the ban has been aimed very clearly at her. She'd phoned her son to come up on Sunday - he wouldn't give an answer, phoning back in half an hour to say he'd come and do her curtain track. Her sister Vera in town had sent word that Mrs Jackson is never to come to her house again.

Mrs Patterson, a younger woman bereaved of her small daughter and determinedly tough-minded about her future, describes conflict with her mother:

> She said there was a brick wall between her and her mother, no communication. The problem wasn't going to go away, she said - she'd have to find a way of resolving it. She complained that her mother was such a wet blanket, that she ate little, wore the same clothes every day, never saw her friends. Mrs Patterson said she wanted support from her mother, wanted her mother to say how good the child's life had been - even if it was short. Instead her mother would just look downcast, sigh, and talk of **"poor Helen"**. Mrs Patterson wondered why her mother hadn't had a breakdown.

The nature of the death itself can be a source of difficulty, giving rise to particularly painful or irresolvable emotion. Sudden death is one example:

> Mr Dawlish ran through the events of his wife's death yet again - this time with particular intensity - he'd only been gone for a minute, sixty seconds at the most. She'd just fallen asleep -that's all there was to it. Nobody could understand what a shock that was.

> Mrs Crawford and I talked again over the shock of Ian's death. She still finds it hard to believe he's gone for good - she finds herself thinking in terms of a return at some point. She recalled the day when she couldn't get out of her chair owing to her arthritis and asked him if he felt able to help her. He managed but said, **"Eh, I don't think I'll be able to do this much longer, pet"**. This was the last time he ever helped her to her feet - he was in hospital, dying, by the evening. Again she described him holding her hand, falling asleep, waking and saying, **"Eh, I'm sorry love"**. These were his last words, she said. She went outside and never saw him alive again.

Similarly the tragically sudden if not unanticipated death of a child:

> Mrs Patterson and her mother took the three children up to a remote seaside cottage. Helen's shallow breathing became very apparent to Mrs Patterson and, although her mother thought it wasn't serious, they took Helen back to the hospital in the city, leaving the two other children in the cottage. The doctor felt nothing serious was afoot but decided to keep Helen in for a few days. Mrs Patterson decided to leave her mother with Helen, rather than staying herself - she went back up to the two other children in the cottage. Helen was very close to her grandmother. Helen's condition deteriorated and on the Friday, two days later, the police came to Mrs Patterson in the cottage, telling her to phone the hospital. She found that Helen was now on a ventilator. In her panic she locked herself out of the cottage - had to get the police again to let her in. Eventually she set off for the city but Helen was already dead by the time she arrived. She had died very suddenly and peacefully, Mrs Patterson was told. Mrs Patterson described fragments of what had happened afterwards. She was amazed at how physical the shock was - she felt as if a storm had broken out all around her. Her legs wouldn't hold her up - the hospital refused to let her drive - she had a sudden kidney infection over the weekend.

In the same vein deaths in unusual or complex circumstances may not be easy to mourn. One woman's ex-husband (whom she had left without explicit warning, for another man) was killed in a road accident within months of his remarriage. As his ambiguous 'widow' the woman felt dispossessed of her right to grieve, finding herself nonetheless obsessed with thoughts of him and frequently overwhelmed by unexpected tears in public places.

Finally, difficulties arise when individuals long committed to a rigid control of their emotional experience encounter the overwhelming emotional chaos of a bereavement. When the ineffectiveness of this strategy is discovered, agitated activity can ensue. One childless widow frenziedly pursued driving lessons and heavy gardening (both at home and in the churchyard) in addition to a demanding full-time job. Severe weightloss and deeply depressed lethargy ensued within months. Another widow, an ex-nurse, had long committed herself to the role of a 'tower of strength' - this both within her village and throughout the long terminal illnesses of her sister-in-law and her husband. Though she accepted a minimum of counselling visits she begrudged herself the possibility of support and fought on in effort to overcome her grief.

Each of the examples selected in this section describes barriers of one kind or another which lie between the bereaved person and their entry into, and relinquishing of grief. Particularly distressing deaths, severe social isolation and a deep reluctance to submit to painful emotion can conspire to maintain the bereaved person betwixt and between the life that is lost and the life that lies ahead. With difficulty, and over time, separating boundaries of this kind can be so transformed as to become mediating links. Past event, when framed as present text, can be progressively re-contextualised in such a way that a new and more sufferable set of referential meanings can be read out of it.

1.1 Avoidance and Exposure: the Experience of Grief.

The uneven process of grieving can be illuminated by descriptions of the passage, or lack of movement, through bereavement offered by particular individuals who sought help from Cruse. Exclusion from the death owing to medical intervention is often an initial grievance, a final parting in absentia being a source of recurrent pain. Often it is only when that physical closeness is figuratively restored through repeated reminiscence, then to be lost again, that the dead can be effectively mourned:

> Mrs Crawford recalled being in the ambulance with Ian - he told her not to worry, it couldn't be a heart-attack - he knew the symptoms and he hadn't had them. He was sedated on arrival at the hospital and she had to wait outside - she wanted to keep going in to see him but they wouldn't let her. When the specialist was sent for at about 4 a.m. she knew it must be very serious and began to give up hope. Again she said that if only he'd known what was happening to him, if he hadn't been sedated, he would have fought against it.

> Mrs Jackson described Gordon's death again - how they'd pretended that they hadn't been sent for specially, even though he was actually dying. They were asked to leave for the last ten minutes when he was given oxygen.

If bereaved people managed to retain some control over the corpse after death it is cited as a source of comfort - an experience of powerful intimacy which was referred to repeatedly at successive visits:

> Mrs Crawford said she'll never forget the journey back to the house without Ian, leaving his body there in the hospital. She had his body brought back to the house (later) and got great comfort from sitting with him.

> Mrs Crawford got so much comfort from having Ian's body in the house, stroking it, sitting by it - he'd looked so nice, all the wrinkles gone.

Three extracts from fieldnotes made on three successive visits to Mr Dawlish illustrate the use of repetition by bereaved people:[4]

> Mr Dawlish and I came back again to Majorie's death and this time he talked in more detail about his feelings. He told me how he'd helped the undertaker to move her body onto the bier where she'd lain until the funeral. He kept popping in and out to see her as she lay there. I commented that people often found it comforting to have the body at home. He said he wouldn't have had it any other way - he wouldn't want her going off to any hospital - **"She was mine. She was mine"** he said with great emphasis. (28.1.83)

> Mr Dawlish didn't phone the undertakers until the next morning - **"What could they do ? They couldn't do anything then"**. Mr Dawlish said she was **"comfortable"** where she was - her body stayed warm until morning, tucked up in bed. He told me how he helped the undertaker move her onto the board. He preferred to be present. He'd always want to do this for one of **"his own"**. (24.2.83)

And again:

> Mr Dawlish told me about Majorie's death - he left her in bed all night - **"She was comfortable there. She wouldn't take any hurt. She kept nice and warm 'til morning. She was mine. She was my wife"**. (17.4.83)

Particularly revealing is the way in which bereaved individuals cite objects and events within their present environment which stimulate their feelings of grief for the lost past. In every example what is being described is the juxtaposition or overlapping of a now figurative, shared 'life' and a current solitary existence. It is through encounters of this kind that the now figurative nature of that lost 'life' is discovered - and

the literal reality of death is slowly encountered. Only though this painful discovery can existence begin to be enlivened.

> Mrs Patterson has been finding it very hard going out without the pushchair. She described Helen as being very much her child, a safety valve during all the stress she has been through. She isn't upset by seeing her friend's children of the same age -they're not Helen. What she does find hard is going to the places she would visit with Helen - the market on a Saturday morning, Marks and Spencers where Helen always carried the basket in the pushchair, the local playground, friend's houses.
>
> Mrs Crawford mentioned some of the moments when grief strikes unexpectedly - going into the garage to find the tools exactly as Ian left them; having to get the bus back from town when Ian once would have met her with the car; seeing all the married people from the Handicapped Centre being taken home by their husbands while she waited for the transport provided; wanting information and not being able to ask Ian who could always answer any query.
>
> Mrs Patterson's father had died at about retirement age. She recalled him planting roses in her garden one cold, wet weekend. He'd died the following day - she recalled going back to look at the roses, finding his gardening shoes where he'd left them. Tears rose slightly at the mention of these shoes - the only point during the evening at which this happened to her.
>
> Mrs Crawford said that the only upsetting thing about Christmas was the electronic games which she had discovered in the wardrobe. Ian had bought these the previous autumn as Christmas presents. Mrs Crawford was unsure what to do about them but decided to ask her daughter if she would like the one Ian had bought for her - it was his last gift. Her daughter burst into floods of tears and said she couldn't possibly - it would be too upsetting.

And significantly it is encounters of this kind which are often avoided:

> **"Do you sit out in the garden ?"** I asked Mrs Crawford. **"No - it brings back too many memories."** She'd brought down the patio table but hasn't taken it out.

> Talking of Gordon's possessions Mrs Jackson said that although she gave most of his clothes to her brother-in-law she has kept a few things for sentimental reasons. Yet she doesn't like to look at them as they upset her.

> Mr Dawlish said his sister-in-law did him **"a favour"** this weekend. She'd taken all Majorie's clothes as they fitted her. He's given away all Majorie's jewellery to his daughter. He stressed that this was the only sensible thing to do - there was no point in keeping lots of things - he has cupboards full of belongings.

> Mrs Crawford said that Ian's stereo set is in the other room - recently bought. She hasn't been able to put on a record since his death.

In addition to stimuli of this kind, bereaved individuals recount their changing perception and experience, over time, of formerly familiar times and spaces - for example the seasons, calendrical events, times of the day. Thus the 'ordinary' spaces of home and garden, and the 'ordinary' times of summer or Christmas, take on a 'non-ordinary' role as the temporal and spatial frame which discloses the empty space within. Again, painful though these disclosures may be, they constitute the process of grieving which is taking place.

> Mrs Crawford and I looked at the garden - it rained and she obviously felt gloomy about this. Her gardener is doing her patio for her - I suggested it could become a very nice place for her to sit out. She said she couldn't ever see herself sitting out there

again. She said she sees Ian so much in the garden - he was always there - she ran through the events of his last days again - how he was clearing up the leaves. She told him to leave the lawn as he was complaining of a pain - to think that a few days later he was dead.

Mrs Crawford talked about the garden. She has all the equipment for a pool which Ian planned to make. She's not really interested in getting it done now - she just wants the terrace finished off and tidied up. She feels that so many of the things she cared about and enjoyed with Ian are now empty and meaningless - all the large ornaments in the house which they brought back from holidays, the Wedgewood dinner service. She can't see herself using it again - it will just sit there. She never sits in the lounge on her own (only when I'm there). She spends her time in the little dining-room. She feels she should make the effort but at the moment it just emphasises her loneliness.

Mrs Crawford said that Christmas was really awful. They'd always made a really big thing of Christmas with lots of presents and food. Her daughter wanted none of this and Mrs Crawford went along with this. They just sat and waited for the day to pass - they wanted to shut it out. They went to bed at about 10.30 p.m.

Mrs Patterson talked about the summer - how much better the children looked in summer - that was when she took photos, then and at Christmas. She thinks next summer will be very hard without Helen - all her most recent memories are associated with hot days and Helen playing in the garden or at the park.

Mrs Patterson is worried about Christmas at school. Younger sisters and brothers are customarily taken up to the platform at the carol concert and also taken to Santa after the party. Other years Natalie, her daughter, would rush up and grab Helen from Mrs Patterson and take her to Santa. Her son and daughter, Allan and Natalie, will miss Helen sharply then.

I asked Mrs Crawford if she was getting any more interested in television or the radio. She said she always used to enjoy Jimmy Young's morning programmes but hasn't switched it on since Ian's death - it would draw her attention to the times at which he would have gone out and then come back for lunch. She's not ready for that at the moment.

Mrs Patterson talked of waking in the morning and missing Helen very badly. Helen was always first up and now Mrs Patterson hears young children, just moved in, waking in the adjoining house - she takes a minute or two to realise that it is not Helen. Natalie misses her badly in the mornings too - she would always look after her and get her dressed.

It was still raining outside and again Mrs Patterson said she'd been feeling really bad. Very much a sense of the 'excitement' having died down - **"routine has set in"** she said - and it was the changes and the gaps in the routine which were bringing home to her the reality of Helen's death - things like the children coming home from school and Helen not being there to greet them.

It appears that Mrs Patterson continues to feel very down, sitting on her own in the evenings. If she has been anywhere, such as the school dance, she finds herself coming down to earth with a bang afterwards. When I phoned her after the dance she said it had been awful going back into the house knowing that she'd been out enjoying herself and that Helen still wasn't back in her bed.

Mrs Crawford said she feels Ian's presence in the house more and more strongly. She now has a happy feeling when she comes back into it after she's been out. Previously it just felt desperately empty. She feels she would never leave it now - all the ornaments are full of significance as she and Ian chose them together. They are very much a point of contact with him. Ian seems close at hand now and she knows they will never be parted - she looks forward to being with him again after death - a communion of souls.

Bodily memories surface too as bodily experience changes:

> Mrs Patterson said she feels an insistent longing for Helen even though she knows she can't have her.

1.2 The Interpretive Process.

The conversation which takes place between bereaved person and counsellor can be seen as an event or social context which embodies particular meanings or implies a particular interpretive framework. In describing their experience of grief, bereaved people are subjecting their own intense, inchoate emotion and their extensive personal memories to processes of selection and ordering. What emerges are external verbal forms which the counsellor in turn seeks to edit or clarify. The product is an account, existing outside of themselves, which the bereaved person then submits to further processes of interpretation. Parallels emerge between the telling of such accounts and the creating of the song, 'Hope', by the residents of Highfield House. Both processes involve a retrospective reinterpretation of the past and its relationship with, and implications for, the present and the future. Being so painfully appropriate, the residents' song came to grief, failing to be performed. If bereaved individuals are able to recall and re-tell those most painful experiences of their past, they come to a necessary grief, one which allows them to move forward into life.

The interpretive process can take a number of forms. For example, in describing the loss to a counsellor, bereaved people may draw upon metaphor in order to communicate their private experience - and in so doing give form to that experience:

> Mr Dawlish said he felt like a train which had been going along the same track all its life and suddenly there was no track any longer - or like a horse which had suddenly lost its driver.

> Mr Dawlish speaks of Majorie with great fondness - her pleasantness - how canny she was - how she never complained - also of her wilfulness, her funny ways. He feels he's 'lost his guiding light' in her - he really can't make the effort to get out.

Giving form to the experience of loss is closely bound up with giving meaning to it. The question 'why ?', at times seemingly unanswerable, nonetheless pre-occupies bereaved people.

> Mrs Crawford said that there's no one person who she means everything to now - she's not special to anyone. She still can't understand why it had to happen, why she's been left like this.

What takes place between the bereaved person and the counsellor during the hours of the visits, can be seen as an embodiment of the more extensive process of 'coming to grief' which takes place through Hospice care. Both the individual counsellor and the institution of the Hospice represent sets of cultural assumptions about the nature of loss - for example that it should be carefully embraced rather than avoided or controlled; that it involves a more distressing and more extended experience than 'outsiders' may envisage; that it is an enriching process rather than a permanently impoverished state. Furthermore the style of caring made use of by both counsellor and institution embodies the ideas of selfless giving oriented towards the very particular needs of another individual; and of a willingness to enter extensively into the intense, painful experience of others. It is within this implicit cultural framework that bereaved and dying people seek to come to terms with their own experience.

Material from counselling visits shows that in retrospect deaths are often located within a framework of some kind. The events of life are re-appraised and a reinterpretation is constructed, or attempted, which can make timely and predictable the most unexpected death. The details of medical history are offered as

by far the most common response to questions about the timeliness of a death. Significant conversations about illness between members of the deceased's family and between any one of those members and a doctor are often repeated verbatim. During visits to bereaved people memories of events which are resistant to an interpretive process are repeatedly brought out and examined.

> When Mrs Crawford's daughter joined us she said it had seemed impossible - her father had thought himself indestructible, there was never anything wrong with him - everyone else believed him. Mrs Crawford said it had always been her who was to look after. She'd say to Ian **"What would I do without you !"** - and he'd reply **"Well you haven't to do without me. I'm here and I'll always be here."** **"And now he's not"** said Mrs Crawford.

> The only time Mrs Crawford can remember Ian going out alone was to a friend's retirement drink. He'd been very concerned that she'd be alright without him and returned almost exactly at the time promised - he said **"If you don't go to their retirement drinks, they'll not come to yours"** - she repeated this with quite some bitterness and irony - Ian never got his retirement drink.

Interpretations may be in terms of 'luck':

> Helen's condition was diagnosed as Lee's disease and was of genetic origin. Mrs Patterson repeatedly talked in terms of luck. She and her husband just happened to have some kind of genetic matching which could give rise to this disease - and it had. Always she talked of luck - good and bad - of the terrible seven years she has been through.

They may be in terms of significant dates:

> Mr Dawlish talked repeatedly of the clustering of significant dates in December and January - the death of his fiance on December 7th; his marriage to Majorie on December 7th, two years later; his own, Majorie's and his daughter's birthdays in these months; his son-in-law's

death in December.

Areas of experience thought of as 'religious' or 'supernatural' are often invoked by way of an interpretation of the death. For example:

> Mr Dawlish said he feels cheated about missing Majorie's death - she often made him promise to hold her hand as she died. Had she often talked of death ? Yes - she often said she was ready to go, though she also asked if she was going to get better. He always told her she would, though he knew she wouldn't. Did she believe in an afterlife ? He said they were both Christians and believed there must be something after death. He described a night several years previously when Majorie had taken aspirin, whisky and a sleeping pill, inadvertently. He woke to find her body completely cold and no heart beat. He shook her and called her until eventually she came to. She described a vivid dream of crossing a bridge, going towards her father who beckoned her from the other side, holding out his hands towards her. Her father had been dead for seven or eight years at this time. Mr Dawlish described the dream with great force and emotional intensity. He said it was only him shaking Majorie that had brought her back from the bridge. Mr Dawlish finds dreams like this convincing, if confusing evidence of a life to come. He can't see how this life can be everything. He said you could go very very deeply into all these things - and still not really have any answers. No-one has ever come back to tell us. There's only one way to find out and he's not ready for that yet. **"I'm not dying to find out."** However he does hope to see Majorie again - though his hopes are far from concrete.

Mr Dawlish said **"Majorie had a premonition, you know, that she was going to die."** Apparently they were sitting together in the back room, the evening she died. She clutched his arm suddenly and said **"Look at that figure dressed all in black going between the doors."** Mr Dawlish said that she must have seen the Figure of Death coming for her. Once settled down for bed she died very suddenly.

Mrs Crawford said **"Do you know the strangest thing happened to me on Thursday, Jennifer."** She described sitting over her lunch in the back room, drinking tea, when she looked down and saw Ian's face very very clearly in the carpet. She sat and looked at it for about ten minutes - it was complete in every detail, the greying hair, the moustache. It was still, like a coloured photo. She eventually got up to make a phone call thinking that from now on it would always be there, that she would be able to go back and look at it whenever she liked. Returning she found it was gone and, although she has looked for it since, she hasn't seen it again. She found it comforting and felt it supported her impression that Ian was very present in the house and that she would meet him again.

Mrs Crawford had read 'A Grief Observed'. She said she'd never questioned God in the way C.S. Lewis does - not even in the early days. She feels sure there must be something after death - she can't believe this is all there is. She'd hate to think she wouldn't see Ian again. What did I think ? She said although she'd never questioned God she did wonder why Ian died when he did. She believes everything happens with a purpose - its all laid down for us.

Mrs Patterson described a conversation with her daughter, Natalie, who'd been talking a lot about Helen, Natalie's dead sister - Natalie kept wanting to know where she was, what was happening to her. Mrs Patterson said that Helen was in heaven, that she was happy. Mrs Patterson said Natalie kept 'harping on' about this. She said she couldn't see how Helen could be happy without them all. She said she knew what was happening to Helen - she was lying in the ground and all her skin and flesh were rotting away, falling off her bones. Mrs Patterson asked her where on earth she'd got this idea from. Natalie said she'd been watching all this happening to a little bird, lying dead in the garden. Mrs Patterson went on to say that Helen didn't need her body any longer - it was only useful in this world, for getting about from place to place - it was her thoughts and her mind which were in heaven. Mrs Patterson felt she was beginning

> to get out of her depth at this point. Natalie took this to mean that her brain had gone to heaven and said, **"Well that's not very nice if that's what heaven is like. A lot of brains walking about."** Mrs Patterson said she herself thinks of Helen as being in heaven - she has to for her own comfort. As a child she thought of heaven in terms of comfort, as a place full of cushions and sunshine where everyone wore pajamas and could jump around as they pleased.

Alongside this assemblage of insiders' interpretive accounts of their own experience of bereavement can be set a description of a day in the life of day-care patients visiting Strathcarron Hospice. What the bereaved person tells or re-enacts, and what the dying person experiences, constitutes the process of encountering and coming to terms with death, their own or that of a close relative or friend. It is this encounter, whether anticipatory or retrospective, which has been a primary focus throughout the thesis. From the broad scope of earlier discussion this chapter now concludes with a very detailed, descriptive account of the experiences of those individuals who were encountering death in Strathcarron Hospice during the spring of 1983. Compiled from fieldnotes, it describes the quality of experience which awaits the dying, or bereaved, person as they make entry into the space of the hospice.

As suggested patients at Strathcarron Hospice are drawn largely from working class communities to the south of Stirling. In accepting Hospice care they submit to a move out of their own cultural and social context and into a middle-class sphere, pervaded throughout by a Christian ambiance. Within this setting transformative processes of a cultural, social, emotional or medical nature may ensue - processes which encompass, and affect a new reintegration of former experiences. By noting in detail the varied sights, sounds, social encounters and pastimes, some novel, some deeply familiar to the incomer, a picture emerges of a very gentle yet inexorable encounter with the imminence of death.

2 STRATHCARRON HOSPICE: ENTRY TO EXIT

A larger crowd than usual gathers on a Friday morning in the sombre wood-panelled room at the end of the corridor. They have been brought from home to the foot of the outside steps by voluntary chauffeurs, homely, middle-class women and a few retired men. A wheelchair or a supporting arm steers them into the pine-scented hallway, wood-panelled too and dimly-lit. Some have come from grey brown council houses on desolate Falkirk estates, out of the shabby, damp-smelling glamour of densely patterned furnishings and outsize, plastic three-piece suites. Others leave behind modest stone-built cottages in the scattering of villages at the foot of the Ochils, untidy double-beds set up behind net-curtained bay-windows in front rooms. Commodes, potties and morphine-laden bedside tables reveal current pre-occupations.

Among these passengers many have cancer and most are expected to die within months. Through their consultant or their GP they have been referred to the country mansion, the local 'big house', set half-way between Stirling and Falkirk. The change in their bodies has precipitated regular journeys out of a modest and now constrained workaday domesticity and away into the more imposing dimensions of the former mansion of the owner of a local paper-mill.

In late middle-age some passengers have learned quickly of their condition, struggled at night times with the knowledge. Wigs and headscarfs are a telling mask for their hair-loss by chemotherapy, the fear-provoking procedure which certifies the condition. Older passengers, long-retired, perhaps resident in old people's homes, are less sure. Referral to the destination known as Strathcarron Hospice, signifies little more than a tiresome and seemingly pointless change in routine.

In states of mind and body such as these, all are brought, alone or with a relative, between the stone gate-posts at the top of Randolph Hill. Beyond lie three and a half acres of carefully cultivated parkland, through which a curving driveway leads the patient to the double glass doors of the hospice. Concrete steps plus ramp plus extensive handrails suggest the particularity of its function. Ascent accomplished, a waiting stretcher trolley, and a distinctively scented atmosphere confirm speculation. Prints of waves breaking, of Impressionist yachts at sunset, ease the passage into a hallway/stairwell reception and here a mosaic impression of handcraft and medicine confronts the patient.

The carefully sustained, seemingly limitless warmth of their voluntary chauffeur is now mirrored in the greeting of voluntary receptionists. Embroidering or knitting patch blankets, the receptionist is framed within a scene of 'Guess-my-Birthday' baby dolls; a glimpsed sluice room; inert, crochet-blanketed bodies and collapsed, waiting wheelchairs. Rarely empty, this space is a meeting point. Four doorways and the staircase provide entry for sombre-suited doctors, administrators, undertakers and the chaplain; for white and blue uniformed female nurses and domestics; and for less readily-identifiable female home-care nurses, voluntary helpers and the social worker. Loudly humourous greetings and a quieter and more urgent exchange of messages merge in an atmosphere of heady seriousness. Threading their way through this public space towards toilets and lounge, in-patients may sometimes be identified by dressing-gown or by hand-held catheter bag. In other cases slippers and a slow tread are the only indication.

Moving into this space, greeted by the receptionist, the cancer-bearing visitor is appropriated by those around them, drawn into role as a member of the social category 'day-care patient'. Double doors beyond open to reveal the destination of the day, the meeting place of Friday's larger crowd than usual.

Entry to this room confers membership of the day-care category. Faltering or refusal is not uncommon. The music, the cigarette smoke and the noise and bustle of activity can overwhelm the timid and the very weak. They seek a return to the peacefully predictable routines of previous months' isolation in sick room or residential home. Those who persist are edged by relative or chauffeur into large armchairs among a group of up to a dozen people. Again greetings are readily offered; again the handwork. In armchairs, wheelchairs or on a settee the group is assembled around a coffee table at the lighter end of this panelled room. To their left and right, corner windows give onto the entrance driveway. Between the tomato plants they have been helped to grow, they glimpse the hospice traffic of cars, delivery vans and hearses.

Fred Challis is a regular member of this group. He is brought in throughout the week yet appears reassuringly bronzed and full-cheeked. In 1982 his face appeared in the medical director's publication, 'Terminal Care'. In 1983 the hospice bulletin reports Fred, 'the doyen of our patients', being photographed with the day-care sister for a poster advertising the hospice. The first arrival every morning, he establishes his solid presence on the settee beneath the window, spreading his rugwork across his knees. Fred is indeed the 'doyen' or senior member among this transitory group of dying people. Visually prominent, featured in hospice publicity, Fred is not about to die. His tumour has been removed but for more than a year he has continued to pass his days in these familiar surroundings while his daughter is at work nearby. Fred is chronically deaf. Though a greeting for new arrivals often comes first from Fred, there is little by way of further conversation. He remains as a silent and reassuringly whole representative of the category of terminally ill people into which the newcomer has been introduced.

Those who cluster about Fred and those who sit apart in the darker end of the room are similarly difficult to identify with any precision. Most are in their sixties, many appear resigned, withdrawn or weary. Fiona McIntyre sits in an armchair near Fred. She is composed, alert, ready to respond or to argue though her eyes may be closed when conversation begins. Her immaculate, stylish suits, her jewellery and her hairdo suggest a business woman, tired now but still ready to correct the ill-informed or reproach a complainer. Many assume she is a visitor but Fiona is growing smaller, greyer and more lined as the weeks pass. Her external elegance conceals the catheter bag strapped to her leg. Little remains of her bladder now. For months the hospice had been Fiona's country hotel, the refuge which she booked in and out of, apologising when her need arose. Now she leaves the hospice only occasionally. She has labelled all the possessions in her flat, given away jewellery and electrical goods where she saw a need. With the menu for her funeral tea drawn up, the outfit she will wear in her coffin selected, she passes her days as best she can, knitting little string dishclothes and threading together plastic purses.

Mr Farr has been brought in by a volunteer from his austere council house in Stirling. He is older than Fiona or Fred, wiry and thin with a pinched, wistful face. Long years of independent bachelorhood and a highly successful career in gardening lie behind him. Around his house a garden flourishes still, carefully tended. Corms recovered from the cellar bloom extravagantly in the kitchen and an old wireless and a dependable wind-up clock sustain him through evenings in the sparsely-furnished living-room. Mr Farr's speech is spare, delivered in a husky, fading voice. The day-care sister has squeezed him into the centre of the group, tucked in beside Fred and his rug on the settee. He frets quietly. He doesn't want to come all this way just to sit about all day. He expected some kind of treatment and wonders why they can't discover what is

wrong with him.

At Fiona'a suggestion Mr Farr selects a thriller from the bookcase opposite but his restlessness persists. The Council have recently renovated his house, taken down the picture rails he used to hang his 'good mirrors', replaced his locks with ill-fitting aluminium substitutes, trampled some of his plants. He needs to get home, he needs to place his bets for the 3.30, he needs to see some improvement in his condition.

Morag Watson has taken the place beside Fiona. In her eighties she fills her armchair amply. She is a little breathless and large dark eyes beneath fluffy, white hair betray a controlled sense of anxiety. She and Fiona recognise one another as pals. When Morag was brought into the hospice from an 'Eventide Home' she was desperate for companionship and found it in Fiona. She is expansively warm, talking repeatedly of how marvellous Fiona was to her when she arrived, what a wonderful person she is. Ever-impressed by Fiona's stoicism, Morag feels put to shame by her, horrified by an unexpected glimpse of Fiona's wound. Morag's symptoms have been effectively brought under control since her admission. Like Fred she has no further urgent need for care but dreads a return to the 'Eventide Home'. The vitality of her friendship with Fiona, her own openness, echoed in the warmth of her children and grandchildren who visit daily, are all felt throughout the hospice. Declared 'good for morale', she is allowed to stay on, enjoying both days and nights at Fiona's side.

Other day-care visitors crowd in around this foursome. A small, swarthy man edges his wheelchair close to the table. Iain is in his forties, suffering from multiple schlerosis. He hammers small wooden stools together, dispensing a strong undercurrent of camaraderie. Ada Waters and Vera Duffy respond, talking with urgency about rent increases. Ada visits occasionally, with some difficulty. Last year she was a constant figure in this

room, strong and supportive towards Hamish, her husband who was to die on New Year's Eve. She gave little thought to the emptiness which lay ahead and braves an overwhelming sense of loss as she walks alone now, up the hill to the hospice seeking sympathetic company. Vera Duffy's deep and forceful voice sustains the conversation, joking and challenging. She is reconciled to her cancer now and brings a home-made dumpling for Michael Dunn, a young, motherless victim of Friedrich's Ataxia, the motor-neurone disease more dreaded within the hospice than cancer itself.

Across the room another man in his sixties sits alone, squarely and placidly. When approached he is responsive and welcoming but grey-faced, hair harshly shorn. His gait is slow and awkward but he shows pleasure in movement and talks animatedly of the hip replacement operations he has just undergone. In the ward behind him, May, his wife, is deteriorating rapidly. They came from Ireland together, years and years before, childless, devoted to one another, staunch Roman Catholics. She lived in the hospice while his hips were replaced, taking small plastic bags of her own fruit across when she visited him in Falkirk. On his recovery she went home delightedly, **"to be with my man"**. Determinedly asserting her **"improvement"** she refused to go back **"over there"** and he agonised in a silent attempt to **"keep it from her"**. Now he and his unemployed friend, Paddy, keep glum vigil at her bedside. The statuette of the Virgin Mary beside her on the locker has been brought expressly from Italy by the home-help. He intends it to be placed alongside her in the coffin.

In the darkest corner of the day-care room, under another print of waves breaking, a younger couple smoke together in silence. Boredom and strain mix in their thin features. The care they commit themselves to giving to the elderly man in the ward nearby is barely received. The woman's father has extensive brain secondaries and his rambling, incoherent speech and his

blindness confound all who would nurse or comfort him.

Though this Friday crowd is large it is not atypical. In-patients, day-patients, relatives and the bereaved all take their places alongside one another. For much of the day they may be left somewhat to their own devices. Pain, grief, boredom and fatigue can easily stifle fluent conversation. All are careful to defer to the possible suffering of another. Though the vitality of patients such as Fred, Fiona and Morag reassures, the motionless, emaciated bodies in the wards beyond can sober the impulse towards a too-buoyant humour or a too-bitter complaint.

Day-care is intended by staff as a gentle introduction to the hospice. It represents an offer to patients of company, an ample meal, handwork and medical supervision. The more that trust and familiarity can be established within the patient, the less severe their suffering is predicted to become.

In the confines of the dark-panelled room at the end of the building, encounters with illness, dying and bereavement are inevitable. The transition from first diagnosis to final bereavement, with each and every slow stage in between, all find some expression in such very mixed groups. As time passes day-care patients may prune the frequency of their visits. Shared lifts and long hours in adjoining armchairs facilitate an intimacy which is inevitably vulnerable to the uneven progress of different tumours. Violet Charlton isn't there this Friday. She's already pointed out how hard it is making friends with **"ladies"** and then they die.

> **"Its alright for the nurses"**, she says,
> **"its their job. Its no so good when**
> **you're one of the passengers".**

The existing hospice is to be extended over the next few years. Priority is being given to new, subdivided day-care facilities to the east of the present room, nearer still to the main road.

Additional wards are to come later. They will extend southwards, away towards farmland at the back of the hospice. A covered corridor will link this south-facing extension with the morgue at the western extremity of the building, thus providing an external and quite separate route for the passage of bodies.

Plans such as these extend and enhance the offer of day-care, the gentle introduction to a company of the dying. In addition, design choices have been made which will serve to create separations between the various social categories to whose members the hospice offers care. In today's context such distinctions blur, giving rise to ambiguities and uncertainties. In the offer of a space for patients such as Fred Challis and Morag Watson, certain ambiguities are fostered. Their presence, together with a proliferation of the voluntary, the homely and the hand-stitched, soften the anticipation of a final and ultimate transition to the small mortuary rooms at the far end of the building. The anticipation itself is nonetheless inevitable. In the present circumstances, juxtapositions of physical pain, grief, fatigue and fear are encountered frequently.

Mr Farr is taken outside by a volunteer to ease his restlessness. The stocking of the flower beds around the hospice interests him, provoking long reminiscence of even grander gardens he has tended. Newly-laid flags draw him among the beds, leading him up the pathway which skirts the large windows of the main ward. He pulls only a token weed, his gaze drawn away inside the building. **"Are these the wards then ?"** he asks. He pauses, seeming to want to say or hear more, but remains silent.

Mr Farr is spending his Friday in this way because he has chosen to accept an offer. Though the day-care sister extends the offer welcomingly, she is an NHS-trained nurse and a little bemused by her responsibility for a service which is entirely optional yet deemed highly valuable for patients. Patients' difficulty in

interpreting and responding to signs of ill-health or distress among fellow visitors is matched by staff's uncertainty in the fostering of an appropriate atmosphere among day-care patients. Notions of a suitable mode of caring vary considerably among staff. In conscious opposition to the routinisation of hospital practises, they have made an explicit commitment to very flexible caring, determined by the needs and wishes of the individual.

Inevitably it is an ethos which is subject to a circumstance in which many individuals, the unwell, the dying, the soon-to- be-bereaved and the grieving, share a confined space.

Mary Saunders, the hospice social worker, is a single woman in her early forties. In a village some fifteen miles from the hospice, her small flat gives evidence of a solitary and devotional way of life. Her personal response to those individuals who withdraw, overwhelmed by public exposure in the crowded day-care room, is powerful. Her offers of rescue are prompt. Mary states openly that the lack of privacy and peace in the hospice alarms her and she strives to stifle the noise of laughter and the thud of footsteps.

Margaret Owen, day-care sister, approaches such issues from a different perspective. Together in their small, shared office, she self-mockingly mimics her 'big sell' for day-care. With a few dance steps, she announces crafts, parties and an outing to the Edinburgh Tatoo. As a nurse, she is indeed bemused by her role as hostess to the newly-diagnosed. She has developed an approach in which the element of choice is elaborated. Margaret iniates activities or events. Their outcome is unpredictable, a matter of choice among patients. She interprets potentially distressing encounters or separations according to current ideologies which stress the therapeutic value of honesty and frankness.

Those who cluster at the coffee table this Friday are offered the possibility of a slide show by Margaret. For an hour or so they have been helped by an ex-handicraft teacher to stitch fluffy toy animals. Fiona and Morag have worked in silent concentration at one another's sides, responsive to this brief respite from dish-clothes and plastic purses. The day-care sister's initial suggestion of slides has been accepted and the question of including the bed-ridden arises. Undaunted by the fact that the men in the adjoining ward are too ill to come through, she enlists support to re-establish the day-care group (plus screen and projector) in among them. The upheaval is enormous. Meal trolleys are folded away, pot plants stacked up on the window sill and the ward coffee table is pushed out into the garden. Curtains are drawn, leads trail and all access to the adjoining nurses' station is blocked by a tight bunching of chairs. The day-care group move through slowly, in ones and twos. With care they take seats, concerned not to obscure a neighbour's view or disturb the four men lying in this ward. The men's beds, set among a busy clutter of lockers and wardrobes, take up most of the space in this further, high-panelled room.

In moving through, at Margaret's rather than Mary's suggestion, the orientation has shifted away from the comings and goings of the entrance thoroughfare towards a view of sunlit, stone-walled lawns, screened by a long clustering of well-established trees. Sunlight floods through large ward windows. Tom Renshaw, on the right, lies motionless, yellowing and emaciated. So conspicuously ill is he that only a close inspection reveals signs of life. His eyes lie half-open, as in death, but their remote, thoughtful gaze is directed towards the light, suggesting a passenger on watch as a shoreline recedes. He is dying very slowly and his wife's large, handsome face is crumbling with the alcohol necessary for yet more visiting. Watching the new and growing dissimilarity between the faces of Tom and his brother, she makes loud, brash remarks:

"They're all the same, these bloody Renshaws. I really fancy you in that state Tom"

The warm and gentle style of fifty hospice staff jolts in the face of her defiance.

Billy Charlton's wife is no longer a visitor but now a quasi-staff member. In a hospice apron she tends him throughout the day, a critical substitute for his body's lost mobility. Humour, vitality and expressiveness are now crowded exclusively upon his large well-made head. Below, a naked conglomeration of torso, twisted lifeless arms and a remaining, soon-to-be-amputated leg all lie ill-concealed beneath crochet blankets on an aluminium bed cradle. The healthy, almost joyful, cast of his features contrasts noticeably with an unsmiling weariness in the face of the wife beside him.

Roger Harmer sprawls across a bed to the back of the room. Florid and plump, he shows no external signs of disease. Dressed still, in thick blue cardigan and belted, crimplene trousers, he appears angrily discontent. His admission to the hospice is the staff's attempt to give his family a break. He promised to have no contact with them for a fortnight but already he has phoned here and there, always with a different and more worrying account of his plans. Staff tire rapidly of his complaints about food, smoking and television.

On the bed opposite, sightless Tommy Farquar mumbles, shifting from side to side, always disturbingly close to the next stumbling foray into the room.

Margaret erects the screen, curtains are drawn and the unfocussed slide show begins. The material for this August morning's event is drawn from two earlier occasions, a Burns Night hotel supper and a Christmas-time hospice party. Slides show staff in

unfamiliar evening-wear, elaborate, formal and glamourous, clustered together at candle-lit tables. With dry humour, Margaret establishes a sense of benign voyeurism among the day-care audience, pointing out large jugs of orange juice when alcohol is clearly more central to the occasion. Playing upon an atmosphere of mock titillation, she introduces further shots with a comment, **"Lots of money has been offered for us to suppress some of these pictures"**. They show staff in other, more bizarre guises. Santa, the Pied Piper, two grotesquely fleshly fairies, Worzel Gummidge, a giant gangling baby, a St.Trinians' schoolgirl and Buttons are all seen to cavort in the same, familiar setting as the morning's slide-show.

The day-care audience laughs afresh as they witness the surprise juxtapositions of this revealing masquerade. On the slides another audience is seen to witness the carnival. They too are familiar members of the in-patient/day-patient categories and today's audience calls out their names in school-room unison. On her bed a woman is seen to indulge in the 'good things' of life, cigarette hanging from her lips, beer bottle lying in her hand and huge pants strung from the bedrail with a note asking Santa to fill them. Only a chill, an inaudible sigh, acknowledges the transience of the dead audience, frozen on the translucent plastic of the slides.

Tom Renshaw has now fallen asleep and Roger Harmer ceases to pretend any interest. Fred Challis complains that at least fifteen slides were omitted, the ones in which he appeared. Margaret offers to retrieve them but the others are tiring, they have seen enough. She notes that Tom is asleep, **"Well, that shows it was a nice soothing show"**. Slowly the ward is restored to its original order. **"Well that was a nice little morning interlude"**, she concludes.

For those who visited the hospice for day-care, the anticipation of a frightening future has been gently advanced in the few slow paces from day-care room to ward. The interlude to which they were entertained drew them still further forward in a shared retrieval of the familiar names of those who have preceded them. Making use the value attributed to honesty in current ideologies of terminal care, Margaret defines the interlude as **"good grief therapy"**. And then begins to speculate about the effect on Fred Challis and Fiona of being party to so very many deaths. Theory tempts her again and she raises the possibility of **"measuring the effect"**.

In this, as in all such day-care 'interludes', a lively entertainment involves an encounter with death. A party on the previous Friday afternoon led day-care patients to seats outside and 'Chateau Strathcarron', the wine they had been helped to make. As quiche and fresh-cream strawberry tarts were handed round, beds were trundled heavily from wards and out over flagstones. Each one bore the immobile body of a dying patient, their condition made pitifully evident in the strong, early afternoon sunshine. Seeking to overcome the slightly nervous formality common to the early stages of parties everywhere, Margaret asked if anyone could sing. Though most staff were already retiring to the periphery of the group, a few visiting relatives, a volunteer driver and two volunteer/students remained among patients. Jimmy Robb, the driver, was swift to accept this further opportunity to volunteer himself. In a resonant and determinedly vibrato voice, Jimmy worked his way through each verse of a series of sentimental Scots ballads. The introduction of yodelling in the third song brought the company to the brink of mild, stifled hysteria. Harold Allan, a former psychiatric patient now seated at the bedside of his child-like, dying wife, rose in spiky blonde wig to offer a similar if more restrained rendering of yet another Scots ballad. Michael Dunn, the young man whose control of his vocal chords has been largely eroded by motor-neurone disease, was then pressed to attempt 'Michael Row

the Boat Ashore'. As he struggled to produce some appropriate sounds, the balance of the entire event hovered delicately between the wildly farcical and the desperately tragic.

The group who had clustered in bright sunshine, exposed for a brief, intense hour to the extraordinary frailty of the human condition, retained their places. The sun moved lower in the sky and they sat on in the gentler light, relaxed and mellowing. Making no move, they were approached by volunteers for their orders for tea, and mixed grills, chips and roasted cheese were all carried out to them. In ones and twos they eventually made a chauffeur-driven return to cottages and council houses.

Fridays are the high-spot of the day-care week. Events such as the two described, proliferate on this day. Those visitors who persist, who accept membership of the day-care category, are party to incidents and events which invariably further the anticipation of increasing deterioration and death. In a rich variety of guises, staff draw them, in whatever comfort may be possible, from the east to the west end of the building. As they step out from front doorsteps into the cars of ready volunteers, they become passengers whose transience is to be very gently and carefully brought home to them.

NOTES

1. See Chapter Ten.

2. See Chapter Seven, pages 218-219.

3. See Chapter Seven, pages 196-214.

4. See also Chapter Seven, pages 201-203.

CONCLUSION

The thesis began by presenting an anthropological approach to the topic, 'death'. Using such an approach, it was argued that in any particular cultural and social context death is managed according to and as an expression of the prevailing values and concerns of that society. In attending to the historical and the contemporary cultural and social contexts within which deaths are managed, anthropology makes one part of its unique contribution to the study of death. The first half of the thesis comprises a far-ranging discussion of both the historical and the broad contemporary context of the management of death in Great Britain today. Out of this discussion comes the means of exploring the minutiae of quite specific field contexts - a hermeneutic approach which explores acts, events and utterances through their relationship to a wider context. The human encounter with death is lived out at this varied, immediate, and personal level. It is, ultimately, to the quality of this experience that the thesis is addressed.

Experiences such as those presented in the thesis have been described very graphically in literary work, and measured and explained very extensively in medical and sociological studies. However there remains the question of meaning - of how experience comes into being and how it is interpreted.

For example, Hinton (1979) attempted to measure emotions such as anger, anxiety and depression among cancer patients dying in different contexts, a Home, a hospital and a hospice. Questionnaires submitted to statistical analysis revealed that:

> ...human reactions to dying are often ambiguous and inconsistent.

Hinton goes on:

> ...this, and the imprecise ratings of troubled feelings may well cause scientific dismay in a study where several factors were not controlled.
> (1979:32)

Whilst ratings indicated that hospice patients experienced least distress the paper includes little discussion of how a particular quality of experience comes to arise in that context. It is the connecting of utterance and setting, text and context, which anthropology works towards, that can deepen the (self) understanding of dying people and their carers. Ratings, however accurate, can do little more than inform.

In the second half of the thesis the process of hermeneutic analysis is demonstrated. In this way the cultural and social meaning of personal experiences can be understood. Ricoeur's extensive work on hermeneutics is the primary theoretical source drawn upon in this discussion. As noted, his conception of human thought as essentially metaphoric in character has been taken up in the work of Lakoff and Johnson (1980). It is also a theoretical starting point for many social anthropologists, for example Geertz, Fernandez and Tambiah. Given the understanding that meaning, whether of act/event/utterance, arises out of the cultural metaphors through which an act or an utterance is conceived and perceived, anthropologists have addressed themselves to the ways in which meaning becomes open to manipulation. Through fieldwork, the researcher can immerse themselves in the lived cultural and social world, the time and the space within which meaning comes into being. Ricoeur's work on the way in which meaning accrues to a text through its being-in-the-world, and the way in which meaning is predicated upon the world through the presence of the text, can inform the study of action. Tambiah (1979:115) describes ritual as being 'open to contextual meanings'. That is to say, that meaning is not tied fixedly to even the most regular and stereotyped actions

or utterances which take place within the world. Rather it is susceptible to both subtle and also dramatic shifts. For example, figurative references to death begin to take on an additional, literal dimension once framed within the space of a residential home for elderly people, or a hospice, and the time of a slowly dwindling life. From this perspective detailed exchanges between nurse and patient, or an individual's memories, their personal style, and their private feelings become interpretible, and their meaning can be read out. In the same vein, broadly prevailing practises such as the institutionalisation of very elderly people can be made sense of when set within the context of the historical roots of contemporary cultural frameworks.

With the essentials of my own, familiar death history made explicit, I moved into the broad sphere of the history of Western thought. Concepts of health and sickness provided points of orientation. The tension between fragmentation and flow emerges as a central conceptual opposition which permeates the later field material. Ethnographic material from selected, smaller scale, more traditional societies introduced the idea that the biological boundary between life and death is often an important focus for cultural and social elaboration. Material was drawn from societies where the maintenance of ethnic identity/purity or the controlled linking of carefully separated cultural and social categories are key structuring principles. Within the broader field of dominant, contemporary Western society, the nature of the boundary between life and death was also shown to be critical to the way in which death is managed. The breakdown of the interpretive cultural frameworks of the Middle Ages - through which an interconnectedness was perceived between the universe and human experience - was followed by the emergence of analytic models which allowed for the control of the natural world through the growth of specialist forms of knowledge. Control through fragmentation, through the maintenance of rigid social, spatial and temporal as well as conceptual boundaries, is the

contemporary context of ageing, dying and bereavement. This most global of global structures was traced in three specific and contrasting passages from life to death and from death to life - a residential home for elderly people, a hospice, and bereavement counselling. They were selected for more intensive study in the second half of the thesis, being drawn from areas which remain peripheral and often threatening to such a world view.

With the theme of a shift away from flow or interconnectedness and towards control through fragmentation firmly established, otherwise confused and emotionally disturbing personal experience is increasingly entered into - in the more detailed and personal style used to present the extensive ethnographic material of Chapters Ten and Eleven. Using a more literary approach I have reintegrated the conversations and the daily lives of bereaved and dying individuals in order to exemplify and expand upon points developed in the theoretical discussion of earlier chapters. In the course of the movement out from my own personal death history and back into the personal lives of such individuals, attention has been given, by turn, to specific and concrete field contexts and also to the broad overarching concepts which permeate them.

At its outset the thesis argues that responses to deaths arise out of and are brought to order through ritual processes. They are performances within which the literal grounding of a society's root metaphors are powerfully presented and manipulated. Through participation in performances of this kind an individual's responses to a death may be both inspired and also given coherence.

Involvement, through fieldwork, in such processes, be they of a religious, medical or domestic nature, represents a second part of the anthropologist's special contribution to this field of study. In any encounter with death, with the unknown and intangible event which bounds the human lifespan, everyday

utterances, gestures, objects and practises take on an intensified resonance - and therein lies scope for the manipulation of meanings. As noted, this area is central to a specifically anthropological approach. It is a predominant theme within the thesis. Through the contrasting examples of the residential home for elderly people and the hospice, a hermeneutic analysis of the manipulation of metaphor, of the fusion and confusion of the figurative and the literal, reveals the possibility of both deflecting and also directing the individual's awareness of the fate of their own and others' bodies.

A parallel strand throughout the thesis has been the nature of anthropological research methods and their place within a Western cultural and social milieu. In the move towards a more holistic approach to dying, as exemplified by the Hospice Movement, can be seen parallels with an anthropological perspective which seeks to reveal and to reintegrate the continuities within existing, apparently objective bodies of specialist knowledge.[1] The specialisation of knowledge and the dividing up of the continuum of human experience are two closely interlinked aspects of the post-Cartesian worldview. Through an anthropological perspective the relationship between apparently disparate areas such as the emergence of 'the problem of the elderly', the spatial separation of living and dying, and the nature of the Western 'self' can be elucidated. Brought together they can be seen as the wider cultural and social context of the black humour and the vestigial material belongings of very elderly people living and dying in a residential home in the North East of England. The rich semantic resonance of apparently banal if sad events or utterances can then be read out. In a context such as the residential home, where a figurative 'life'/ 'death' boundary is rigorously maintained, the integrative research methods of the social anthropologist reveal residents' muted attempts to transcend the de-humanising fragmentation of their memories and of their remaining lifespan.

Within the thesis the marginalising of categories of experience, and the resulting segregation of associated social categories, is a major theme - and the study of the nature of boundaries is an important focus within an anthropological approach. Thus, for example, this perspective allows the debate about setting up hospices as separate spaces for dying[2] to be effectively illuminated by placing discussion within the broader context of the ritual separation of disorder in societies throughout the world. In an earlier example[3] a parallel was drawn between the segregation of death-related experience and the figurative accessibility of a now marginalised 'wildlife' within an urban domestic context. Both cases can be seen as outcomes of the development of technological control over the natural world. 'Nature', like death, has been withdrawn from everyday experience in its literal manifestations and, in their place, a vestigial, fictional representation is offered for contemplation.

Landscape painting provides one final example of the usefulness of this analogy. Berger (1980) offers a revealing discussion of the ideological implications of the relationship between landcape and figures in such work, taking up the question of control and distancing as a human orientation towards the natural world. In the work of Millet, Berger shows the artist seeking to bring figures, the peasant, out of the 'genre' corner of landscape painting and into the foreground, thereby revealing them as dignified human beings working upon the land (1980:69-78). Berger asserts that Millet fails because he makes use of the language of traditional oil painting, one which cannot accommodate such a subject. Its implicit aim is to portray the distanced landscape seen by the urban visitor and not the experienced landscape worked upon by the rural peasant.

Berger pursues this theme in the work of Seker Ahmet, a Turkish painter who studied in Paris and went on to introduce a European perspective into Turkish art (1980:79-86). Taking Ahmet's

painting 'Woodcutter in the Forest', Berger explores the disjunction between the traditions of European and Persian art as revealed in the spatial ambiguity of this picture. Seen through Western eyes the pre-impressionist style of this painting places it firmly within the tradition of landscape-to-be-looked-at. Nevertheless Ahmet's depiction of space is, disturbingly, in the Persian tradition. The forest advances, wraps itself around the figure, and the work is made convincingly true to the in-the-forest experience of the woodcutter. Berger also refers to an exhibition of Chinese landscape painting, the work of peasants themselves. Few showed the sky or indeed an horizon. Again the viewer is offered not a vista but an account of the experience of working within a landscape. Berger sums up:

> The attraction and the terror of the forest is that you see yourself in it as Jonah was in the whale's belly. Although it has limits, it is closed around you. Now this experience, which is that of anybody familiar with forests, depends upon your seeing yourself in double vision. You make your way through the forest and, simultaneously, you see yourself, as from the outside, swallowed by the forest.
>
> Seker Ahmet...faced the forest as a thing taking place in itself, as a presence that was so pressing that he could not, as he had learnt to do in Paris, maintain his distance from it.

In focussing on the work of two painters who departed, slightly, from a traditional Western language of oil painting, Berger suggests the possibility of the natural world being experienced in qualitatively different ways, depending on the social class of the observer/participant. In Europe, oil paintings were commissioned by individuals sufficiently wealthy and powerful to exercise choice over the space between themselves and the natural world. Berger's comparison between Western and non-Western art reveals the profound implications of this choice, or the lack of it, with respect to the way in which the natural world is experienced.

By analogy, Berger's writing raises the possibility of the same area of human experience being perceived as both seamless, all-encompassing and unbounded, and also as a separate whole, as something which can be socially, spatially and conceptually set apart from the self.

It is this possibility which has been the focus of the thesis. Like Berger, I have explored material which is peripheral to a dominant, controlling cultural system - that is, ageing, bereavement and the innovative approaches of Hospice and bereavement counselling organisations. Millet and Seker Ahmet both worked on the margins of the mainstream of traditional concepts of art. As innovator and as outsider, they made ammendments to prevailing practice. As such their work provides insights, developed by Berger, into an otherwise 'given' way of seeing the natural world.

Thus they not only draw attention to the particularity of such a way of seeing, and therefore to its association with one, powerful, social category, but in ammending that perception, bring into view those working experiences of the landscape which lie undepicted and therefore invisible or muted within an existing, dominant, cultural framework.

As argued, the deterioration that ageing can involve, the painful early death that cancer can bring, and the overwhelming, isolating emotional distress that a bereavement can precipitate, are all aspects of human experience which lie beyond or outside existing cultural frameworks. Thus these processes reveal the limitations of a curative, controlling medical model; they undermine images of human life as a state of enduring, independent 'adulthood'; and they challenge the management of emotional experience through distancing, control and the maintenance of privacy.

As a whole, the thesis stresses the distancing and the disguise of death-related experience as a prevailing cultural orientation. However, like the peasant who continued to work upon and to experience the landscape from within, sick, very elderly and bereaved people, nurses, care aids, the police and funeral directors all continue to spend part if not all their lives engaged directly with death. An example from fieldnotes written during my stay at Strathcarron Hospice illustrates the experience of the 'insider'.

Ted is in his sixties, recovering from major hip surgery. His wife, May is about to die of cancer in the hospice. He spends most of his time at her bedside or in the day-care room:

> His main concerns at the moment were that as many of the family as possible would be able to get up and see her before she died - he feared she wouldn't live much longer than the weekend - he was going home to get food in, unsure as to where the visitors would stay ... I took him home later - a strange emotional state he displays - dying is what's going on - like Christmas, the spring, childcare - the details of changes in health, arrival of visitors and so on are what pre-occupies the mind - death frames it all and cannot be contemplated directly.

C.S. Lewis echoes this point in a description of his wife becoming aware that she was suffering from terminal cancer:

> When the reality came, the name and the idea were in some degree disarmed. And up to a point I very nearly understood. This is important. One never meets just Cancer, or War, or Unhappiness (or Happiness). One only meets each hour or moment that comes. All manner of ups and downs. Many bad spots in our best times, many good ones in our worst. One never gets the total impact of what we call 'the thing itself'. (1961:14)

What the thesis shows is how encounters with death such as Ted's have come to be confined within the experience of members of the quite specific, often marginalised social categories indicated above. In Ted's case, that of an individual who is being bereaved within the care of a hospice, his entry into a separate and specific social category involves a carefully managed encounter with death. The prevailing boundaries through which life and death have been separated are deliberately transcended. By contrast there are individuals such as those confined within residential institutions or isolated within very private experiences of bereavement, for whom the encounter with death takes on a highly idiosyncratic or sometimes permanently paralysing character. Two examples are the residents at Highfield House whose assertions of the imminence of their deaths are one of the few remaining strategies through which their individuality or identity may be maintained; and lone, elderly survivors of very exclusive marriages who remain to a large extent immobilised within a figurative past 'life', ever vulnerable to the emotional pain of a present literal 'death'.

Thus for worse or for better such individuals remain in some senses secluded in their proximity to death. Throughout the thesis two complementary strands have been pursued - the strategies through which their seclusion, whatever its form, is created and maintained, and the cultural frameworks or metaphors through which such individuals perceive and experience their encounters with death.

The first half of the thesis looks back over nearly two thousand years of Western history. Further research can usefully look forward. Projected statistics concerning the distribution of age within future populations are available. A top-heavy structure is predicted.[4] A protracted period of ageing awaits many of us. Others will find themselves responsible for lengthy periods of carework as members of their families live on into extreme old age. Loss, dependency and the imminence of death, three major

themes within the thesis, all occur, often simultaneously, as the individual ages. As institutional support for elderly people succumbs to economic cutbacks, so concern is growing about stress experienced by female family members obliged to care for an elderly relative with little emotional or financial support.

Capra (1982) notes the presence of disparate groups within society, all of them implicitly addressing themselves to the same problematic area, the fragmentation of knowledge, experience and the natural world. 'Care', whether of the whole earth or of the individual, is a common preoccupation. Nonetheless, links between groups such as the Women's Movement, the Green Party, the New Age movement for spiritual growth and the Peace Movement, are as yet tenuous. Awareness of the shared nature of their concerns is only partly evolved. With respect to the 'death-awareness' movement, currently committed to transforming of the management of death, there is a need to transcend its early, necessarily 'separatist' approach. The flood of popular writing which assails those, such as myself, working within this field, is often not perceived by those for whom death remains personally rather remote. Death education, like sex education, can perform the important role of sensitising those who currently remain sheltered, opening them up to the developments which are afoot.

In their supportive as well as their educational role, organisations such as Cruse often fail to forge links with other groups who have a part to play in helping bereaved people. In the case of Cruse, these include general practitioners, health visitors, district nurses and social workers. Rather than working in isolation, linked only to an organisation specialising in bereavement, counsellors might operate far more fruitfully as co-opted members of Health Centres. Similarly, in their approach to counselling, volunteers are not trained in the more experiential modes of therapy such as co-counselling[5] or gestalt.[6] Such methods involve working directly with very powerful emotion and place responsibility for change largely with

the client. Though often perceived as 'threatening' or 'cranky', experiential methods, when carefully managed, can be far more potent than talking when a bereaved person is blocked in the painful confusion of figurative 'life' and literal 'death'. As Capra points out, specialisms can obscure the advantages to be gained through a merger of currently antipathetic approaches. Yet they persist as a still powerful orientation towards the management of human experience and the natural world in the West.

The thesis provides a grounding for exploring the separations between currently diffuse or alienated groups. In particular, the creative tension between concepts such as 'autonomy', 'control' and 'work' and other concepts such as 'dependency', 'care' and 'giving' emerges from the broad sphere of this thesis as a valuable area for further research. It has become apparent that independent adulthood, the limited aim of a prevailing orientation towards 'growth', is inadequate as a model for human life. The Hospice Movement has expanded upon this concept of life, so re-incorporating the experiences of deterioration and dependency. Ideas about 'work', 'control' and 'autonomy' are then called into question as the vulnerability of human beings is acknowledged and given prominence.

As noted previously, death ritual has been an important focus within anthropological work. It offers the researcher insights into the more obscure or implicit issues which pattern everyday life - now writ large at the time of death. The primary theme of this thesis is the human encounter with death. It is the field within which I have been working. In the above suggestions for further study, it is not only death but also the tensions and ambiguities associated with currently muted dimensions of lived experience which emerge as a primary focus for thought.

NOTES

1. See Chapter Two, pages 42-45.

2. See Chapter Six, page 150.

3. See Chapter Three, page 59.

4. The recent increase in the number of people over the age of sixty within the population of Great Britain has now levelled off. However, the 1961 figure of approximately two million people over the age of seventy-five is expected to go on increasing until it comes close to doubling in the year 2001 (Marshall, 1983:7).

5. See Jackins (1975).

6. See Perls (1973)

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